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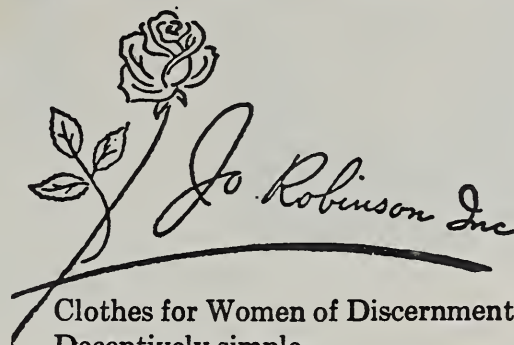
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cancer communiqué

FROM THE DELAWARE CANCER NETWORK*

MEETING NEEDS OF STOMA PATIENTS IN DELAWARE

JOANNE P. TULLY, R.N., M.P.H.
JOHN R. THOMPSON, M.S.W.

In the past year there has been increasing concern expressed about the need for services of an enterostomal therapist for ostomy patients who live outside the greater Wilmington area. This concern has come from enterostomal therapists; health service providers including physicians, other nurses, social workers, and other counselors; and ostomates themselves.

The need for professional care and teaching for all types of ostomy patients has been indicated both locally and nationally by the mutual-aid organization known as the United Ostomy Association. Presently, chapters are operating in all three counties of Delaware and are supported by the American Cancer Society, Delaware Division, Inc.

In response to the expressed need, the Delaware Cancer Network has offered technical and training assistance for Kent and Sussex County hospitals to provide these services. Two hospitals in Sussex County have committed them-

selves to providing enterostomal therapy services by accepting the Network's offer. Within the next year, staff and registered nurses from Beebe and Milford Memorial Hospitals will attend a certified enterostomal therapy training program and return ready to provide this service in their respective hospitals.

The objective of enterostomal therapy is to provide a resource person to the hospital's staff, someone who is able to take time to remain abreast of current developments and who will support general nursing care with specific technical and psychological insight. More specifically, the enterostomal therapist, with the physician's approval, will assess, plan, implement, and evaluate care for patients with colostomies, ileostomies, urinary diversions, and draining wound problems. The therapist can also insure continuity of care of the ostomy patient by improving the competence, performance, and understanding of all hospital personnel.

The therapist's activities may include providing preoperative counseling for patients and families. The skilled nurse, as a stomal therapist,

Ms. Tully is Senior Nurse Coordinator for the Delaware Cancer Network.

Mr. Thompson is Rehabilitation Planner for the Delaware Cancer Network.

*An NCI-supported agency located at 1200 Jefferson Street, Wilmington, Delaware 19801. Tel. (302) 428-2113.

will be aware of physician preferences and collaborate with the patient's primary physician and surgeon regarding the plan of care. Also, the trained therapist may instruct the new ostomate in self-care including stoma care, application of an appliance, diet, management where indicated, odor control, irrigation if necessary, and assistance with obtaining ostomy supplies locally. Arrangements may be made for an Ostomy Association visitor when applicable. Establishing and maintaining enterostomal therapy services to patients on an outpatient basis may also be desirable. Postoperative counseling to assist patients to adjust emotionally to their changed body image is frequently required.

The family physician and the surgeon are responsible for the overall medical, surgical, and emotional well-being of the patient. As an additional team member, the trained enterostomal therapist contributes specialized skills and understanding in managing and rehabilitating the ostomy patient. Rehabilitated patients can then continue to lead useful, satisfying lives.

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DESCRIPTION Each tablet of PERCOCET®-5 contains 5mg oxycodone hydrochloride (WARNING: May be habit forming), 325mg acetaminophen (APAP).

INDICATIONS For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS Hypersensitivity to oxycodone or acetaminophen.

WARNINGS Drug Dependence Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of PERCOCET®-5, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, PERCOCET®-5 is subject to the Federal Controlled Substances Act.

Usage in ambulatory patients Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using PERCOCET®-5 should be cautioned accordingly.

Interaction with other central nervous system depressants Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with PERCOCET®-5 may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Usage in pregnancy Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, PERCOCET®-5 should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Usage in children PERCOCET®-5 should not be administered to children.

PRECAUTIONS Head injury and increased intracranial pressure The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions The administration of PERCOCET®-5 or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special risk patients PERCOCET®-5 should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

ADVERSE REACTIONS The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include euphoria, dysphoria, constipation, skin rash and pruritus.

DOSAGE AND ADMINISTRATION Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. PERCOCET®-5 is given orally. The usual adult dose is one tablet every 6 hours as needed for pain.

DRUG INTERACTIONS The CNS depressant effects of PERCOCET®-5 may be additive with that of other CNS depressants. See WARNINGS.

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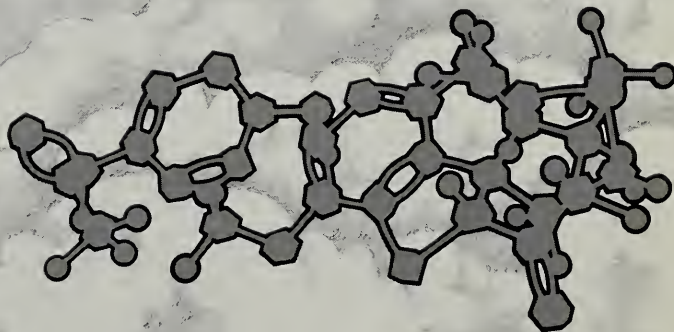
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Please see facing page for Brief Summary of prescribing information.

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All manuscripts submitted shall be original, never before published and contributed solely to the Delaware Medical Journal. They should be addressed to the Editor, 1925 Lovering Avenue, Wilmington, Delaware 19806, who reserves the right to reduce, revise, or reject any material submitted for publication.

Copy should be typewritten, double-spaced on 8½" x 11" white bond paper. In addition to the original, two copies are desirable.

The professional affiliations of each author should be supplied. Uncommon abbreviations should be written out in parentheses the first time they are used. Names, initials, or other information that could identify a patient should be eliminated from the copy. If photographs of patients are used, either the subjects should not be identifiable, or their pictures must be accompanied by written permission to use the figure.

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Manuscripts are customarily examined by the editorial staff and sent out to two reviewers. Authors are usually notified within two to six weeks as to the acceptability of a manuscript, but sometimes longer delays are unavoidable.

Contributors will be notified as soon as a manuscript is received. Unaccepted manuscripts will be returned.

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References should be limited to a reasonable number. References must be numbered in the copy. Bibliographies will not be accepted.

References should conform to the *Index Medicus*, including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher and place of publication, as well.

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1. Fine RN, Brennan LP, Edelbrock HH, et al: Use of pediatric cadaver kidneys for homotransplantation in children. *JAMA* 210:477-484, 1969.

Example of a book:

(2) Morgan WL, Engel GL: *The Clinical Approach to the Patient*, p 85. Philadelphia, WB Saunders Co, 1969.

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Drawings and charts should be made in black ink on white paper. Photographs must be black and white glossy and should be identified on the back and their positions indicated in the text. The cost of reproduction of illustrated material for publication in excess of an average of one illustration per page will be charged to the author. Photographs, drawings, and cuts will be returned after publication only if requested.

Drug Names

Generic names should be used, but if an author uses a brand name drug in the the course of a study, or wishes to use a brand name for other reasons, he may do so, but should insert it (in parentheses) after the generic name.



President's Page

LIFE, DEATH, AND DOLLARS

In its recent program "Medicine in America—Life, Death, and Dollars," NBC reported that expenditures for health care now make the "health industry" the nation's third largest. Health is outranked by only the construction industry and agriculture.

Though it may be surprising to us, this statistic seems only appropriate. Far from being alarming, it accurately reflects the high value our society places on the goal of good health. Spiritual needs do differ, but we all share a common requirement for food, shelter, and health in order to pursue a happy and useful life.

There is another intriguing observation noted by the AMA which has escaped widespread attention. Over the past decade the combined expenditures for health and defense have remained level at 15% of the US gross national product. The health portion has grown to 8%, but this has been funded fully by a reciprocal decrease in monies expended for defense.

As Americans we want no sacrifice of our capacity to defend ourselves, but as doctors I think we know full well there is little waste or "fat" in the money spent for medical research and patient care. Any significant cutback in

these expenditures would make it much more difficult to achieve the kind of healthy world we want for ourselves and the generations to come.

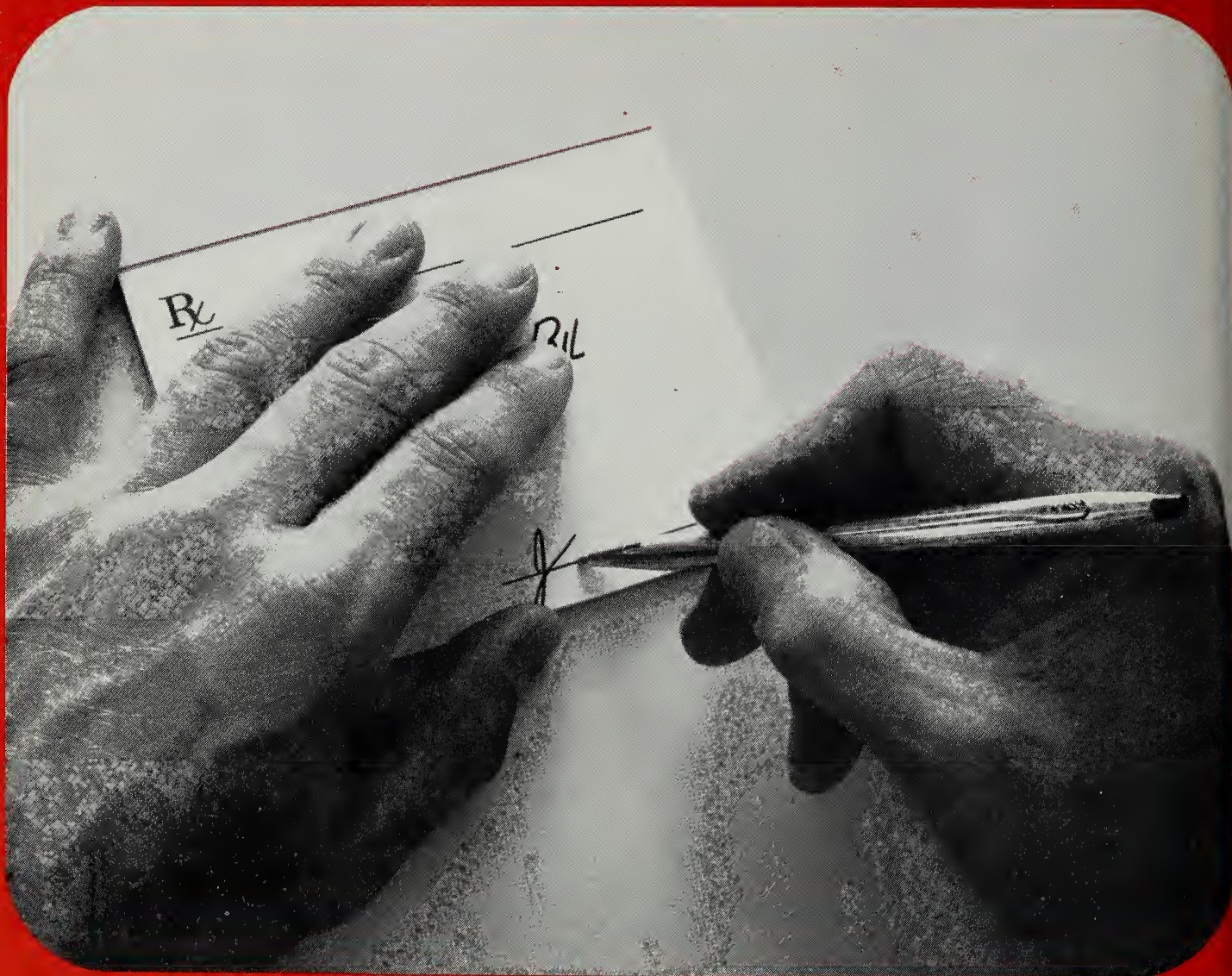
Recently we have had reports showing a decline in the death rate from heart and related diseases. It is not yet low enough for us to rest on our laurels, but it is an indication that our longstanding effort to acquaint our patients with the problems of over-indulgence, untreated hypertension, uncontrolled diabetes, and so forth, is producing results. Not until the past decade or so has longevity been increased for those who have achieved the middle years of life.

Further strides must be made in advancing longevity and improving quality of life through better health. They will cost money. Our profession, our patients, and the public must continue to work together to insure this is spent wisely.

We can be encouraged, however, by the signs that we are putting our values in the right place.

John J. Egan M.D.

There is no substitute



yours...

Contraindications: Anuria; hypersensitivity to this or other sulfonamide-derived drugs.

Warnings: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy.

Use in Pregnancy: Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults.

Nursing Mothers: Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.

Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting ex-

cessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hypokalemia may develop, especially with brisk diuresis, in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, or with inadequate oral electrolyte intake. Hypokalemia can sensitize or exaggerate response of heart to toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal im-

A SURVEY OF DOWN SYNDROME AT THE HOSPITAL FOR THE MENTALLY RETARDED, GEORGETOWN, DELAWARE

ARNOLD M. CLARK, Ph.D.

HENRY R. COWELL, M.D.

ARDYTHE A. MCCrackEN, M.S.

WILHELMINA C. LEY BENNETT, M.D.

DOROTHY W. ADAMS

During the past year the University of Delaware (UD) and the Hospital for the Mentally Retarded (HMR) have studied the hospital residents who have been diagnosed or suspected of having Down Syndrome. The purpose of the study was to compare the clinical diagnosis of this syndrome with the modern methods of chromosomal diagnosis.

Since 1959 it has been known that Down Syndrome is due to the presence of an extra chromosome 21 in the cells,¹ but relatively few HMR residents had been diagnosed by means of chromosomal analysis. The clinical evaluation allowed us to determine the frequency with which the various stigmata appeared in the Down population at HMR; chromosomal analysis gave us the opportunity to check the accuracy of the physical diagnosis.

Dr. Clark is Professor of Genetics, University of Delaware, Newark, Delaware.

Dr. Cowell is Associate Surgeon-in-Chief, Alfred I. duPont Institute, Wilmington, Delaware.

Ms. McCracken is Research Associate in Cytogenetics, University of Delaware, Newark, Delaware.

Dr. Bennett is Director of Maternal and Child Health, State of Delaware.

Ms. Adams is Cytologist, Hospital for the Mentally Retarded, Georgetown, Delaware.

Publication No. 1, from the University of Delaware Cytogenetics Laboratory.

METHOD OF STUDY

Clinical Diagnosis

Seventy-eight patients who had a clinical diagnosis of Down Syndrome recorded on their chart were identified. These patients underwent a complete physical examination by the authors with particular attention being paid to the physical findings noted in a check list of thirty-five items which included all the physical findings which had previously been described with Down Syndrome in the literature.² The examination was carried out by a single physician with a second individual acting as a recorder. All questionable findings were reviewed by two of the authors prior to recording. Upon completion of the physical examination the examiner recorded his clinical impression of the patient in one of three categories. Those individuals who were thought to have at least the minimal diagnostic criteria necessary for an unequivocal diagnosis of Down Syndrome were recorded as "Down positive." Those individuals who had some of the stigmata of Down Syndrome but who did not have sufficient findings to make a definitive diagnosis were classified as "Down

questionable.” The remaining patients who had so few of the findings of Down Syndrome that they did not appear to be Down individuals were grouped as “Down negative.”

Chromosomal Analysis

Blood samples obtained from each patient were cultured at the University of Delaware Cytogenetics Laboratory by standard methods.³ Slides were prepared for analysis of metaphase chromosomes. Slides stained with Giemsa stain were used to make chromosome counts and to record the number of G-type chromosomes (21, 22, Y).⁴

Other slides were immersed in the fluorochrome dye quinacrine mustard and then examined under the fluorescent microscope. This technique enables discrimination among chromosomes 21, 22, and Y.⁵ (Figure 1) The metaphase spread (Figure 1b) and the alignment of these chromosomes (Figure 1a) show that each specific chromosome can be identified. The Y chromosome is easily recognized because of its strong fluorescence; chromosome 21 shows more fluorescence than chromosome 22. (Figure 1a, 1b) The arrow (Figure 1b) points to two 21 chromosomes that are joined together (21-21 translocation).

RESULTS AND DISCUSSION

Clinical Evaluation

Following completion of the cytogenetic studies the physical findings in the cytogenetically positive and negative Down patients were tabulated. A comparison of the findings showed that a number of the physical findings typically seen in Down Syndrome were not helpful in discriminating between the individuals with and without Down Syndrome. For example, small teeth, abnormally aligned teeth, furrowing of the tongue, upslanting palpebral fissures, a flat occipital region, small ears, a flat nasal bridge, and strabismus, while present in 53.7 to 79.7% of the patients with Down Syndrome were also present in 25 to 50% of the patients who did not have chromosomal Down Syndrome. (Table 1)

There were, however, certain findings that were helpful in discriminating between Down and non-Down patients. No Down negative pa-

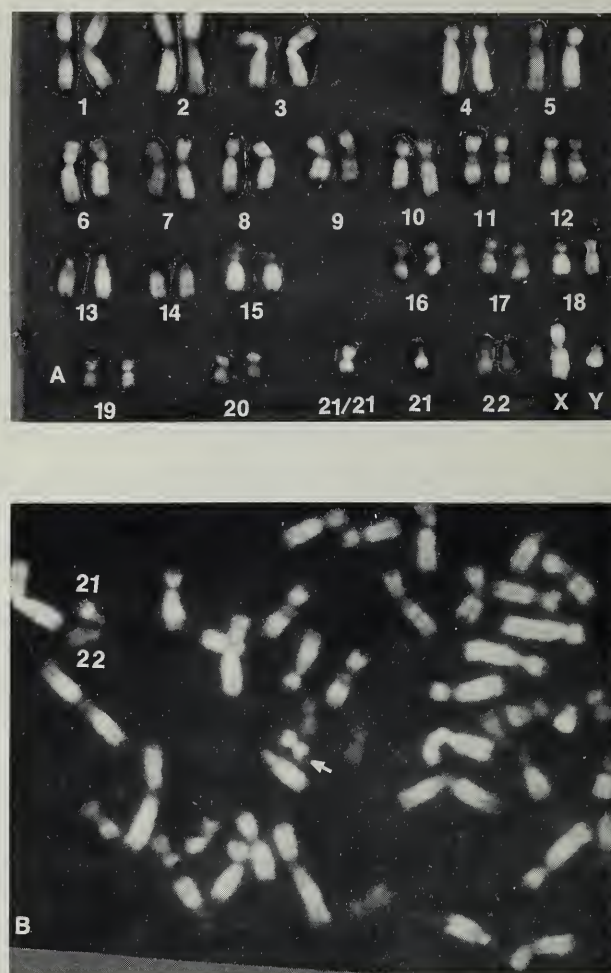


FIGURE 1

These photographs show the karyotype (a) of metaphase chromosome spread (b). The chromosomes were stained with quinacrine mustard and photographed under a fluorescent microscope. Note the alignment of the pairs of chromosomes in a.

tients had definite Brushfield spots, and only one patient who was Down negative had a questionable Brushfield spot. The same was true of skin texture, which was dry in 55.7% of the patients with Down but in only one of the eight non-Down patients (12.5%) A simian crease was present in 44.9% of the patients with Down Syndrome, but no Down negative patient in this population had a simian crease. A large protruding tongue and small orbits were present in 50% and 48.4% respectively, of the patients with Down Syndrome but in only one patient without Down.

TABLE I

Clinical Evaluation of Suspected Down Syndrome in 78 Patients

<u>Findings</u>	<u>Patients with DS</u> <u>expressing trait</u>		<u>Patients without DS</u> <u>expressing trait</u>	
	<u>proportions*</u>	<u>percent</u>	<u>proportions</u>	<u>percent</u>
Small Teeth	43/54	79.6	4/8	50.0
Furrowing of Tongue	55/69	79.7	4/8	50.0
Upslanting Palpebral Fissure	48/69	69.6	3/8	37.5
Flat Occipital Region	44/70	62.9	3/8	37.5
Small Ears	38/68	55.9	2/8	25.0
Flat Nasal Bridge	39/68	57.4	3/8	37.5
Strabismus	36/67	53.7	2/8	25.0
Abnormally Aligned Teeth	30/55	54.5	4/8	50.0
Large Protruding Tongue	35/70	50.0	1/8	12.5
Small Orbits	31/64	48.4	1/8	12.5
Short Nose	33/70	47.1	2/8	25.0
Orthopaedic Findings				
Flat feet	58/68	85.3	1/8	12.5
Widely spaced 1st and 2nd toes	56/68	82.4	0/8	0
Short fingers	56/70	80.0	2/8	25.0
Short neck	53/70	75.7	2/8	25.0
Incurved 5th finger	51/70	72.9	1/8	12.5
Brushfield Spots	37/67	55.2	1/8	12.5
Skin Texture Dry	39/70	55.7	1/8	12.5
Simiam Crease	31/69	44.9	0/8	0

* All patients were not evaluated for every trait.

Of particular interest to us was the fact that certain of the orthopedic findings were also helpful in discriminating between patients with and without Down Syndrome. An in-curving of the fifth finger, flat feet, and a wide space between the first and second toes were present in 72.9% to 85.3% of the patients with Down Syndrome. Flat feet and in-curved fifth fingers were each present once in the eight patients in the Down negative group (12.5%). None of the patients

in the Down negative group had wide spacing between the first and second toes. In addition, short fingers and a short neck were present in 80% and 75.7% respectively of the patients with Down Syndrome, but in only two out of eight patients (25%) who did not have Down Syndrome had these findings.

Review of the eleven patients in the Down questionable group revealed that an accurate

TABLE 2
Frequency of 10 Characteristics
in Patients with Questionable Clinical Diagnosis

Chromosomal Diagnosis	Karyotype Positive							Karyotype Negative			
	+	+	+	+	+	+	+	-	-	-	-
Patient Number	32	49	63	64	72	106	73	34	52	56	95
FINDINGS											
Flat feet	+	-	+	+	+	-	+	+	-	-	-
Widely spaced 1st and 2nd toe	+	-	+	-	+	+	+	-	-	-	-
Short fingers	+	-	+	+	-	+	+	+	-	-	-
Short neck	-	-	+	-	+	+	-	+	-	+	-
Incurved 5th finger	+	-	-	+	+	+	+	-	+	-	-
Brushfield spots	+	-	-	+	+	+	+	-	-	-	-
Skin texture dry	-	-	-	+	+	+	-	-	-	-	+
Simian crease	+	-	-	-	+	-	-	-	-	-	-
Small orbits	+	-	+	-	+	+	-	-	+	-	-
Large protruding tongue	+	-	-	+	+	+	-	-	-	-	-

clinical diagnosis could be made in all but two (No. 34, No. 49) if the above criteria were used. (Table 2) In the Down questionable group six of the seven cytogenetic Down positive individuals had five or more of these physical findings. Only one Down positive individual in this group had none of these physical findings. In the Down questionable group one had three positive findings, one had two, and two had one finding. (Table 2)

Cytogenetic Evaluation

In all, 78 patients initially suspected by HMR as having Down Syndrome were examined. Of these, 63 were clinically diagnosed as Down positive, 11 as Down questionable, and four as Down negative. (Table 3) Those diagnosed as Down negative were shown to have 46 chromosomes, the normal number. The 63 patients diagnosed clinically as Down positive were all

shown to have a chromosomal constitution that is characteristic of Down. Their physical diagnosis was thus consistent with their chromosomal analysis. (Table 3) Chromosomal analysis of the 11 people for whom the clinical diagnosis was questionable showed that four were not Down and seven were. Thus chromosomal analysis could be used to positively identify the Down patients among those clinically questionable.

Chromosomal analysis revealed three cytologic types of Down Syndrome: trisomy 21, mosaic, and translocation.

Simple Down Syndrome, Trisomy 21: 47,XX,+21 or 47,XY,+21

There were 66 patients in this group in whom an extra chromosome 21 was found. This type of abnormality is due to the egg or sperm having

TABLE 3

Comparison of Chromosomal and Clinical Diagnosis

for Down Syndrome Study

Chromosomal Diagnosis	Clinical Diagnosis			
	Number of Patients	Down Positive	Down Questionable	Down Negative
46,XX or 46,XY	8	0	4	4
47,XX,+21 or 47,XY,+21	66	60	6	0
46,XX/47,XX,+21 or 46,XY/47,XY,+21	3	2	1	0
46,XY,-21,+t(21q21q)	1	1	0	0
Totals	78	63	11	4

carried an extra chromosome 21 as a result of nondisjunction during meiosis. It is the most common type of Down. It is not inherited. The risk figure for recurrence usually given to parents who are normal (46,XX or 46,XY) is 1 to 2% for a second child also to be Down, provided the mother is under 30 years of age.⁶ For women over 30, the risk is the same as that usually given to women in this age group.⁶ Pregnant women between 35 and 39 years of age run a risk of 1-2%; for 40-year-old women the risk is 2-3%; for women over 45 years old the risk is 5-10%.⁷

Chromosomal analysis for cells with an extra 21 chromosome (trisomy-21) is presented in Figure 2. Three staining procedures were used: conventional stain (Giemsa), Q-banding (Quinacrine fluorescence), and G-banding (Trypsin-Giemsa). Chromosomes 19 and 20 (F group) and 21, 22, Y (G group) are shown for the normal condition (a) and the trisomy condition (b). With conventional staining, the F and G group chromosomes can be distinguished from each other, but chromosomes within each group cannot be delineated. One can, however, recognize that an extra G group chromosome is present for Down Syndrome (b). With conventional staining, the presence of 47 chromosomes due to trisomy G can be shown, but one is unable to distinguish 21, 22, and Y separately.

Q-banding enables one to recognize each G

group chromosome, 21, 22, Y (Figure 2.2) because the Y chromosome is highly fluorescent, the 21 chromosomes are less fluorescent, and the 22 chromosomes are least fluorescent. This technique represents a refinement of the conventional staining method because of its ability to clearly recognize the 21 chromosome.

The G-banding method also enables recognition of the 21, 22 and Y chromosomes individually. (Figure 2.3)

**Mosaic Down Syndrome: 46,XX/47,XX,+21
46,XY/47,XY,+21**

There were three people in whom some of the body cells had 46 chromosomes while others had 47 chromosomes. This type of Down is caused by a faulty allocation of chromosome 21 occurring during embryonic development. The mosaic condition is not inherited. Current knowledge concerning mosaic Down makes it difficult to predict risk figures for subsequent pregnancies; the risk is tentatively placed at 1/100 based upon empirical data.⁶

Diagnosis is more difficult for mosaics since much of the body is of normal genetic constitution. Two of the mosaics in our series who were diagnosed clinically as "Down positive" showed an extra 21 chromosome in 70% of their lymphocytes. One who was diagnosed as "Down questionable" had the extra 21 chromosome in only 4% of his lymphocytes.

When studying mosaic Down the problems in diagnosis are related to what proportion of the body cells carry an extra 21 chromosome, and in what parts of the body these cells are localized. Problems in genetic counseling arise when dealing with mosaics because the cells bearing the extra 21 chromosome may be present in the testicular or ovarian tissue and may give rise to sperm or eggs with the extra chromosome so that the frequency of Down children may be high. Whenever one finds more than one sibling who is a simple Down, the parents should be studied for chromosomal mosaicism.

**Translocation Down Syndrome:
46,XY,-21,+t(21q21q)**

In our survey there was one male with 46 chromosomes who seemed to have a chromosome 21 missing (-21) but who actually had two chromosomes 21 attached together, a 21-21 translocation, +t(21q21q). (Figure 2,c translocation) The chromosomes 21 were attached by their long (q) arms. With the conventional stain, the two attached 21 chromosomes look like an extra F chromosome (Figure 2.1c arrow), and there appears to be only one chromosome 21. From the Q-banding and G-banding one can recognize that there is a 21-21 translocation. There are three chromosomes 21, but two are attached (Figure 2.1c, 2.2c, 2.3c, arrows). When translocation Down occurs, there is the possibility for such a chromosome to have been inherited from one of the parents, although in about one-half such cases the translocation has arisen *de novo*. This is a potentially high risk group with the risk ranging from 4% to 100% depending upon the type of translocation. For a woman with a 15-21 translocation the risk is 10% while for a man with this translocation the risk is 4%. For people with a 21-21 translocation the risk is 100% to produce a child with Down Syndrome. Genetic counseling and chromosomal analysis should be offered to such a family.

Summary

We evaluated 78 patients who had a diagnosis of Down Syndrome prior to this study. By clinical diagnosis we identified three groups within these 78 patients: Down Syndrome positive, Down Syndrome questionable, and Down Syndrome negative.

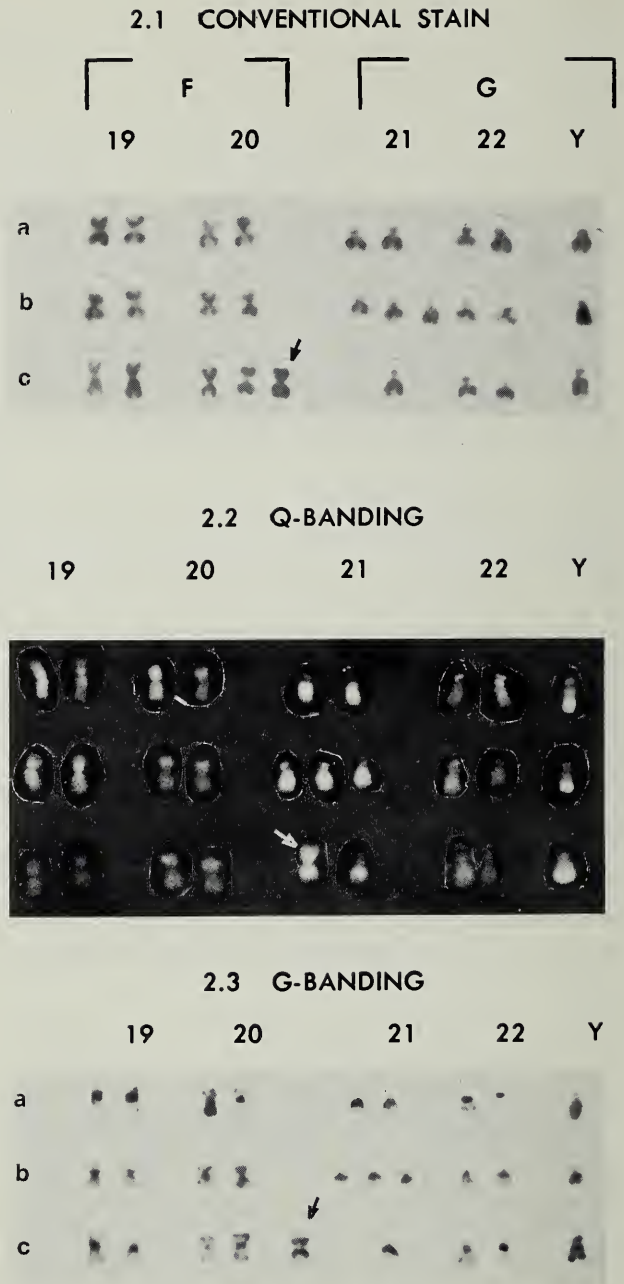


FIGURE 2

These photographs show metaphase chromosomes for the F and G groups. The chromosomes are shown as they appear by conventional stain, Q-banding, and G-banding. In all of the above partial karyotypes a = normal, b = Down trisomy, and c = Down translocation.

Cytogenetic studies confirmed the diagnosis of Down Syndrome positive in 70 of the 78 patients. Of the eight shown by cytogenetic analysis not

to have Down Syndrome, four had previously been classified clinically by us as Down Syndrome negative and four as Down Syndrome, questionable.

A retrospective review of the physical findings recorded for each patient revealed a group of physical findings which would have allowed a definitive diagnosis in seventy-six of the seventy-eight patients. (Table 3) Even if these criteria are shown to be as accurate in other populations of Down Syndrome patients, it would not negate the importance of diagnostic cytogenetics. Analysis of the physical findings cannot determine the chromosomal type of Down Syndrome present in the patient. Since each type of Down Syndrome carries its own risk for recurrence, cytogenetic analysis is imperative for proper counseling of the family.

Conclusion

It has been demonstrated that chromosomal abnormalities contribute to human disease, malformation, and maladjustment. There are approximately 20,000 new cases per year in the United States alone!⁸ Diagnostic cytogenetics should now be used along with other cytological services as an aid to definitive diagnosis.

REFERENCES

1. LeJeune J, Gautier M, Turpin R: Etude des chromosomes somatiques de neuf enfants mongoliens. C R Acad Sci, Paris 248:1721-1722, 1959.
2. Hamerton JL: Human Cytogenetics, vol II Clinical Cytogenetics, pp 206-208. New York, Academic Press, 1971.
3. Moorhead PS, Nowell PC, Mellman WJ, Battips DM, et al: Chromosome preparations of leukocytes cultured from human peripheral blood. Exp Cel Res 20:613-619, 1960.
4. Chicago Conference: Birth Defects Original Article Series, vol II, no 2. New York, The National Foundation, 1966.
5. Paris Conference Birth Defects Original Article Series, vol VIII, no 7. New York, The National Foundation, 1971.
6. Fuhrmann W, Frederick V: Genetic Counseling. New York, Springer-Verlag, 1976.
7. Milunsky A: Know Your Genes. Boston, Houghton Mifflin Co, 1977.
8. Valentine GH: The Chromosome Disorders, An Introduction for Clinicians. Philadelphia, JB Lippincott Co, 1975.

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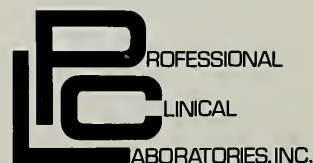
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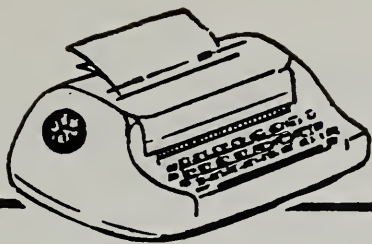
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Special Reports

MEDICAL REQUIREMENTS FOR SCUBA

Each year approximately 200,000 persons take training in the use of scuba. Since the mid-1950's more than two and a half million people have been trained in scuba diving with probably somewhere under a million of these remaining as active divers from year to year. Although these figures do not portend a boom in this sport, it does point up the fact that from time to time most primary physicians are going to examine someone who is either contemplating the sport of scuba diving or who is actively engaged in the sport and is consulting for some other problem.

With affluence in the country rising again and an increased appetite for risky recreation, probably an even greater number of individuals will be seen in the ensuing years who aspire to be weightless spacemen in the underwater world. Because of interest stimulated by television's Jacques Cousteau and by movies such as "Jaws" and "The Deep," the beautiful and fascinating world of the underwater universe keeps beckoning to thousands of prospective novices. Like parachute jumping, hang gliding, and mountain climbing, diving can be risky without proper training.

Because the sport is demanding and complicated, physical conditioning of the applicant is a necessary prerequisite. All nationally recognized training organizations now require physical examinations of prospective divers before they are allowed to undertake scuba training. Commercial training is even more difficult and now comes under federal regulation with regard to the medical standards applicants have to meet. For sport scuba diving, an adequate medical evaluation can be performed by any physician using a limited number of laboratory examinations depending upon the patient's past history and symptomatology. In general, a physical examination plus urinalysis is adequate for young,

healthy adults. For men over the age of forty, a stress electrocardiogram is usually a wise investigative procedure. Any respiratory deviation is best investigated with inspiratory and expiratory chest films. The studies indicated for commercial divers are more extensive and outlined elsewhere.

The following tabulation of temporarily or absolutely disqualifying disabilities is presented to help physicians evaluate would-be divers who have a medical complication with the question arising whether they should be allowed to start or continue diver training. As with all medical evaluations an overall assessment of the patient should be of major importance in determining qualification or disqualification for this sport.

Basic Physical Qualifications of New and Veteran Divers with Particular Emphasis on Pathological Conditions That Are Absolutely Disqualifying or Temporarily Disqualifying

I. Ears

External otitis is temporarily disqualifying until it is cleared up. The patients should be advised in the use of a prophylactic ear drop such as Otobione. The ear drum must be visible, and it must move when the individual performs the Valsalva maneuver. Holes or tears in the drums are temporarily disqualifying until they are fixed. Audiograms and electronystatograms may be helpful as baseline. A stapes mobilization procedure is acceptable for divers, but the insertion of a wire strut to replace the osseous chain in the inner ear is disqualifying. Chronic mastoiditis is disqualifying until it is treated and cleared. A round window blowout of the middle ear is temporarily disqualifying until it is repaired.

II. Nose and Throat

Markedly deviated septums can present a serious problem. Chronic sinusitis should be treated and cleared. Either the teeth should be in good shape, or they should be extracted and replaced with dentures.

III. Eyes

Maximum uncorrected vision of 20/200 should be corrected to 20/20. Color vision should be intact. Contact lenses may be used. It is preferable to use the hard type since the soft type are hydrophilic and tend to become infected with pseudomonas, particularly with saturation divers.

IV. Central Nervous System (CNS)

Any reason to have sudden loss of consciousness is absolutely disqualifying.

- Seizures after the age of five and unassociated with a febrile episode
- Any central nervous system disease such as neurosyphilis, multiple sclerosis, etc.
- Psychosis
- Brain tumor
- Demyelinating process
- Meniere's disease
- Severe migraine
- Head injuries present a series of variables that have to be clinically assessed. Those head injuries which are absolutely disqualifying are:

- Unconsciousness for a period greater than 48 hours
- Depressed skull fracture
- Known brain laceration
- Subdural or epidural hematoma
- Intracerebral hemorrhage
- Post traumatic meningitis
- Rhinorrhea or otorrhea persisting for more than seven days
- Seizure at the time of a head injury
- Any persistent neurological defect
- Any persistent electroencephalogram

change

11. A persistent higher intellectual defect

Individuals would be disqualified for up to two years who have a normal EEG and a normal physical exam but who were unconscious for a period of two to 24 hours with or without a linear skull fracture. Also in this group would be people with post traumatic amnesia for greater than 24 hours and a post traumatic syndrome with a loss of memory, personality changes, and difficulty with equilibrium as long as it does not last over two months.

A diver with a head injury can be returned to diving after a period of three months if he has the following qualifications:

- Only a linear skull fracture with fifteen minutes of unconsciousness or less.
- Loss of consciousness ranging from fifteen minutes to two hours but no fracture.
- Cerebral spinal fluid rhinorrhea or otorrhea lasting less than seven days. Following CNS bends with a spinal cord hit or a brain hit, the diver may be returned to work if his neurological deficit does not persist. If it does persist, he should be disqualified. If there are no symptoms from a spinal cord hit after a period of six weeks and there are no significant findings, then the individual can probably be returned to work. Various factors have to be considered in central nervous system hits such as: Were there multiple hits? How severe were they? What were the circumstances of the dive? Did the man deserve to get what he got



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physiologically? In other words, if the hit is unexpected, then one has to assume that there is some predelection in the diver that makes him more susceptible to early CNS bends.

V. Pulmonary

1. A spontaneous pneumothorax for a new diver should be disqualifying. For veteran divers, if the pulmonary function returns to normal and the x-rays are normal and there is a pressure test to 110 feet in the chamber without difficulty, then that diver can be returned to active work. Recurrent pneumothoraces should be disqualifying for old or new divers. A diver who has had a traumatic pneumothorax that does not leave any functional residual and who has a normal chest x-ray and a normal pressure test to 110 feet can, of course, return to work.
2. Bronchial asthma. If the patient needs medication on a chronic basis for control of this disease, he should be disqualified. If there is a history of severe bronchospasm within the past two years, the patient should be kept out of diving until he has at least a two-year-free interval. If there is any history of bronchospasm on exertion, then this should be disqualifying. A severely atopic individual with asthma should be disqualified.

VI. Cardiovascular System

A myocardial infarction is disqualifying for commercial diving. In sport diving, if the individual has a normal EKG, a normal stress test, and a normal physical examination at six months interval follow-up, then he probably can be returned to sport diving. Hypertension is relatively disqualifying. This is considered as anything greater than 150 systolic over 90 diastolic. The person can dive if he can reduce his blood pressure by weight loss, salt restriction, and the use of diuretics only.

VII. Gastrointestinal System

Peptic ulcers should be considered relatively disqualifying because of the imposed stresses of diving. Recurrent pancreatitis should probably be disqualifying. Diverticulosis or diverticulitis

should be relatively disqualifying because of the fact that these can rupture during decompression and possibly produce a peritonitis.

VIII. Genitourinary System

Stone formers should have a perfectly normal IVP without any evidence of stones in the collecting system, and there should be a minimum period of at least six months to make sure that they aren't in the process of forming any stones.

IX. Skeletal System

Recent fractures, of course, are disqualifying because they can be the site of decompression sickness. These should be completely healed for a minimum of two months. Fractures of the neck, the femur, or the humerus should probably be disqualifying because they can be associated with the site of aseptic necrosis in the future. Low back injuries in the history should be documented, and there should be baseline x-rays to document the status of the patient's skeletal system at the time he begins diving.

X. Aseptic Necrosis

No new diver should be qualified if he has any shaft or juxtaarticular lesions. Old divers are allowed to have shaft lesions, but juxtaarticular lesions should be disqualifying no matter how small.

XI. Skin

Infections of the skin should be temporarily disqualifying until they are cleared up. Chronic furunculosis, psoriasis, and chronic eczema should be disqualifying for saturation divers only.

XII. Endocrine and Hematological System

Adult diabetes should be disqualifying only for divers having to go into remote areas. Sickle cell disease or sickle cell trait can produce aseptic necrosis on its own and therefore should be disqualifying since the relative anoxic state will also invite sickling. Congenital spherocytosis is also disqualifying because the fragile red cells rupture when the patient is breathing high concentrations of oxygen.

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NEW DEVELOPMENTS IN ANTIMICROBIAL THERAPY

MICHAEL F. PARRY, M.D.

Two hundred years ago the treatment of infectious diseases was limited to crude immunization practices, quarantine, and ostracization of the patient. It was not until the late 1800's that the reasons for the effectiveness of quarantine and isolation in the prevention of infection became clear. Except for arsenicals and quinine, however, insignificant progress was made in the chemotherapy of infectious diseases until 1940 when sulfanilamide was discovered. Since that time, numerous antimicrobial agents have been developed, and the field of infectious diseases has changed drastically.

Twenty years ago gram-positive microorganisms accounted for 90% of bacteremic episodes. They now account for only 10 to 20% of cases, and gram-negative microorganisms have become the predominant offenders.¹⁻² Factors responsible for the increase in gram-negative infections include changes in the host, the environment, and its bacterial flora. The human population as a whole is older and therefore subject to more acute and chronic disease. There is increased use of steroids, immunosuppressive drugs, life support systems, and intensive care units. These factors have increased the severity of underlying disease and modified the integrity of host defense mechanisms, important determinants of the type of infections to which these patients are susceptible. Concomitantly, with the modification of host resistance, there has been widespread

use of antibiotics, not only for the treatment of acute infections but also in the management of chronic infections. Such use has promoted the emergence of multi-drug-resistant gram-negative bacteria. It is the prevalence of these microorganisms that has to a large extent been responsible for the pressure to develop new antimicrobial agents.

Severity of the underlying disease continues to be the most important determinant of response to treatment of infectious diseases. However, there is recent evidence to show that agents or combinations of agents which are more active *in vitro* may produce higher clinical response rates. This has been shown in animal models of infectious disease^{3,4} and further suggested in human studies.⁵⁻⁷ The evaluation of each new antimicrobial agent should therefore consider not only its overall antibacterial spectrum, pharmacology, and toxicity, but also its relative activity when compared with other available antibiotics against susceptible microorganisms. Recently introduced agents have been evaluated in this regard, with special attention to their activity against gram-negative microorganisms.

Aminoglycoside antibiotics are extensively employed for the treatment of serious gram-negative bacillary infections. Widespread use of these drugs in the hospital environment has led to increased resistance, resulting in the currently limited usefulness of such agents as streptomycin and kanamycin. The fact that aminoglycoside antibiotics differ widely in their antimicrobial spectrum, however, has allowed the development of more active and presently useful

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Adapted from a presentation made to the Department of Medicine, Wilmington Medical Center, at the Delaware Academy of Medicine.

TABLE 1

GENERIC DRUG	TRADE NAME	Daily Dose (mg/kg)	Normal Dosing Interval (hours)	Normal Half- Life (hours)	Peak Serum Levels ($\mu\text{g/ml}$)
Gentamicin	Garamycin	3-5	q8	1.5-2	5-10
Tobramycin	Nebcin	3-5	q8	1.5-2	5-10
Amikacin	Amikin	15	q8-12	2-2.5	20-30
Carbenicillin	Geopen	300—	q4	1-1.2	250-350
	Pyopen	500			
Ticarcillin	Ticar	200—	q4	1-1.2	175-225
		300			

compounds. (Table 1)

Gentamicin

Gentamicin is particularly useful in the treatment of severe infections due to gram-negative microorganisms, including *Pseudomonas*. Its spectrum of activity includes staphylococci, most members of the *Enterobacteriaceae*, and non-fermentative gram-negative bacilli such as *Pseudomonas*. Like other aminoglycosides, it is not active against streptococci or anaerobic microorganisms. Gentamicin is rapidly absorbed after parenteral administration, reaches peak serum levels 45 minutes after intramuscular administration, has a half-life of 90 minutes, and is distributed in body water except cerebrospinal fluid with an apparent volume of distribution 25% to 40% of body weight.⁸ Gentamicin is not metabolized. It is predominantly excreted by glomerular filtration, necessitating marked reduction in dose in the presence of renal impairment.⁹ It is bound to red blood cells but not to serum proteins.¹⁰

Gentamicin may produce nephrotoxicity, ototoxicity, vestibular toxicity, neuromuscular blockade, and, rarely, bone marrow depression. The development of nephrotoxicity or ototoxicity appears to be correlated most closely with high blood levels of the drug and previous aminoglycoside therapy.¹¹ The development of a widely available serum assay has both minimized the occurrence of toxicity and maximized effectiveness of therapy by allowing determination of adequate therapeutic but non-toxic blood levels.¹¹ There are many testaments to the clinical efficacy

of gentamicin although recent emergence of resistant microorganisms, especially strains of *Pseudomonas*, *Serratia*, and indole-positive *Proteus*, has diminished its usefulness in some centers. It is for this reason that newer agents have been developed.

Tobramycin

Tobramycin is an aminoglycoside antibiotic which is similar to gentamicin in its antimicrobial spectrum. However, it is more active against most strains of *Pseudomonas* and *Acinetobacter* and appears slightly less active against some strains of *E. coli*, *Klebsiella*, and *Serratia*.¹² Its absorption, distribution, and pharmacokinetics are identical to those of gentamicin. Although there is evidence in an animal model that tobramycin may be less toxic than gentamicin, their toxicities appear similar when used for the treatment of infections in seriously ill patients. We have found no difference in the incidence of nephrotoxicity or ototoxicity in a comparative study of 80 patients treated for systemic gram-negative infections with either gentamicin or tobramycin.¹³ Nephrotoxicity, which is usually manifest by transient elevations of BUN or creatinine and the occurrence of cylinduria, has occurred in approximately 5 to 10% of patients receiving either gentamicin or tobramycin.¹¹ Ototoxicity occurs less frequently, and is usually seen in older patients with some degree of renal impairment.¹²

There are little data with which to compare the clinical effectiveness of tobramycin and gen-



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tamicin. Uncontrolled studies support the efficacy of tobramycin, and *in vitro* data suggest that it may be the aminoglycoside of choice for the treatment of *Pseudomonas* infections.¹² One retrospective study has demonstrated no difference in response rates in a group of unselected patients receiving tobramycin or gentamicin.¹⁴

Amikacin

Amikacin is a kanamycin derivative. Its spectrum of activity is wide and includes staphylococci and almost all gram-negative bacilli. Like other aminoglycosides it is not effective against streptococci or anaerobic microorganisms. Its advantage lies in its resistance to hydrolysis by a number of enzymes which may inactivate gentamicin or tobramycin.¹⁵ In large university or metropolitan hospitals with a high incidence of gentamicin-resistant isolates, amikacin has a major role to play; however, many smaller institutions have not yet experienced widespread gentamicin resistance. Allowing for the higher blood levels achievable with amikacin, most gram-negative microorganisms are equivalent in their susceptibility to amikacin or gentamicin, although gentamicin appears superior in its activity against *Serratia*.¹⁶

Amikacin is rapidly absorbed after intramuscular or intravenous administration, reaches peak serum levels 60 to 90 minutes after intramuscular administration, has a half-life of approximately two hours, and is widely distributed in body water with an apparent volume of distribution of 30% of body weight. It does not cross the blood-brain barrier and is not protein bound. As with other aminoglycoside antibiotics it is excreted in the urine and is insignificantly metabolized.¹⁷ The toxicity of amikacin appears similar to that of other aminoglycoside antibiotics. It has been suggested that the ototoxicity of amikacin is greater than that of other aminoglycoside antibiotics,¹⁸ but in two recently published prospective studies, the toxicity of amikacin appeared identical to that of gentamicin and tobramycin.¹⁹⁻²⁰

The clinical efficacy of amikacin has been well documented. It has been particularly effective in severe gram-negative infections due to gentamicin- or tobramycin-resistant microorganisms.²¹⁻²² Controlled studies, however, have not

shown superior clinical response rates when patients are prospectively randomized.¹⁹⁻²⁰ It appears that amikacin offers an advantage over the other currently available aminoglycoside antibiotics only where gentamicin- or tobramycin-resistant strains occur frequently.

The availability of carbenicillin, a thienyl penicillin derivative, has provided an antibiotic that is effective for the treatment of serious infections due to *Pseudomonas* and other gram-negative bacilli; however, the concentrations of carbenicillin needed to inhibit many strains of *Pseudomonas* are close to the maximal levels achievable in man because of cost, toxicity, volume needed for administration, and therefore the drug has limited usefulness.

Ticarcillin

Ticarcillin is a new semisynthetic penicillin which has antimicrobial activity similar to carbenicillin.²³⁻²⁴ It is active against most gram-positive bacteria and many gram-negative microorganisms, including *Pseudomonas* and most members of the *Enterobacteriaceae*. Ticarcillin is also effective against many anaerobic microorganisms, including *Bacteroides fragilis*. It is usually not active against *Klebsiella* or *Serratia* and is not resistant to beta-lactamase. Ticarcillin is significantly more active than carbenicillin against most strains of *Pseudomonas aeruginosa*. Like carbenicillin, it is a disodium salt and contains 5.2 mEq of sodium per gram of drug. Because of its greater anti-*Pseudomonas* activity, however, ticarcillin is used in lower doses than carbenicillin, thereby reducing the sodium load.

Ticarcillin is well distributed to all tissue spaces including the cerebrospinal fluid with an apparent volume distribution of 15 liters.²⁴ It is not acid stable and must be administered parenterally. Peak serum levels of 200 mg per ml are achieved with a normal dose of 50 mg/kg administered intravenously; the half-life in patients with normal renal function is 70 minutes.²⁴⁻³⁵ The half-life rises to 14 hours in patients with renal failure and is further prolonged in the presence of combined hepatic and renal failure.²⁵

Toxicity due to ticarcillin is minimal. Hypersensitivity reactions are similar to those of all penicillin derivatives. Hypokalemia, hemor-

rhagic diatheses due to inhibition of platelet aggregation, and exacerbation of congestive heart failure may occur as they do with carbenicillin. Phlebitis and eosinophilia have been noted in approximately 10% of patients receiving the drug. No nephrotoxicity or ototoxicity has been observed. Hepatotoxicity, manifested by reversible transaminase elevations which is a frequent occurrence with carbenicillin administration, appears less frequent with ticarcillin.¹³

There is a large body of data to show that ticarcillin is both safe and effective for the treatment of systemic infections due to susceptible gram-positive, gram-negative, and anaerobic microorganisms.^{23,26} The results of clinical trials with ticarcillin compare favorably with those of carbenicillin. Colonization with ticarcillin-resistant strains has been frequent during therapy, especially when treating patients with underlying chronic pulmonary disease. The addition of an aminoglycoside antibiotic, however, has not

diminished the colonization rate.²⁷ In most instances colonization with resistant strains has not adversely affected clinical outcome. Clinical superinfection has occurred in some patients and appears mostly to be due to ticarcillin-resistant strains of *Pseudomonas* and *Klebsiella*.

We have found ticarcillin to be particularly useful for the treatment of *Pseudomonas* pulmonary infections. A group of patients with cystic fibrosis and recurrent *Pseudomonas* pulmonary infections has done particularly well when ticarcillin is used in combination with either gentamicin or tobramycin.²⁷ Furthermore, we have found the combination of ticarcillin and tobramycin to be predictably more synergistic than the combination of carbenicillin and gentamicin, and to produce superior clinical results in a group of patients treated for severe systemic *Pseudomonas* infections.¹³

The availability of these new antimicrobial agents represents a significant advance in the

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treatment of systemic gram-negative infections. This is particularly important since the incidence of multi-drug-resistant gram-negative microorganisms appears to be increasing. This increase is due not only to changes in the host and the host's environment, but also to the extensive use of previously available antimicrobial agents. The empiric use of these potentially valuable agents should be discouraged in most circumstances in order to sustain their value in the years to come. Whether they will ultimately prove superior to previously available compounds will depend upon the results of properly conducted, randomized, and controlled prospective clinical studies.

Summary

The frequency with which infections are caused by gram-negative bacilli has risen markedly in recent years. Many of these microorganisms are resistant to commonly used antibiotics; however, the recent introduction of tobramycin, amikacin, and ticarcillin provides effective treatment for many of these infections. The antimicrobial spectrum, pharmacology, toxicity, and potential role of these new agents in the treatment of clinical infectious diseases, have been discussed.

REFERENCES

- McHenry MC, Hawk WA: Bacteremia caused by gram-negative bacilli. *Med Clin N A* 58:623-637, 1974.
- Folff SM, Bennett JV, Editorial: Gram-negative rod bacteremia. *NEJM* 291:733-734, 1974.
- Lumish RM, Norden CW: Therapy of neutropenic rats infected with *Pseudomonas aeruginosa*. *J Infect Dis* 133:538-547, 1976.
- Andriole VT: Antibiotic synergy in experimental infection with *Pseudomonas*. II. The effect of carbenicillin, cephalothin, or cephanone combined with tobramycin or gentamicin. *J Infect Dis* 129:124-133, 1974.
- Myerowitz RL, Medeiros AA, O'Brien TF: Recent experience with bacteremia due to gram-negative organisms. *J Infect Dis* 124:239-246, 1971.
- McCabe WR: Antibiotics and endotoxic shock. *Bull NY Acad Med* 51:1084-1095, 1975.
- Klastersky J, Daneau D, Swings G, et al: Antibacterial activity in serum and urine as a therapeutic guide in bacterial infections. *J Infect Dis* 129:187-193, 1974.
- Siber GR, Echevarria P, Smith AL, et al: Pharmacokinetics of gentamicin in children and adults. *J Infect Dis* 132:637-650, 1975.
- Riff LJ, Jackson GG: Pharmacology of gentamicin in man. *J Infect Dis* 124:S98-S105, 1971.
- Schumacher GE: Practical pharmacokinetic techniques for drug consultation and evaluation. IV. Gentamicin blood levels versus time profiles of various dosage regimens recommended for renal impairment. *Amer J Hosp Pharm* 32:299-308, 1975.
- Hewitt WL: Gentamicin: toxicity in perspective. *Postgrad Med J* 50: Suppl 7:55-59, 1974.
- Neu HC: Tobramycin: An overview. *J Infect Dis* 134:S3-S19, 1976.
- Parry MF, Neu HC: Comparative study of ticarcillin and tobramycin versus carbenicillin and gentamicin for the treatment of systemic gram-negative infections. *Amer J Med In press*.
- Klastersky J, Hensgens C, Henri A, et al: Comparative clinical study of tobramycin and gentamicin. *Antimicrob Agents Chemother* 5:133-138, 1974.
- Price KE, DeFuria MD, Pursiano TA: Amikacin, an aminoglycoside with marked activity against antibiotic-resistant clinical isolates. *J Infect Dis* 134:S249-S261, 1976.
- Rahal JJ, Simberkoff MS, Kagan K, et al: Bacterial efficacy of Sch 20569 and amikacin against gentamicin-sensitive and -resistant organisms. *Antimicrob Agents Chemother* 9:595-599, 1976.
- Plantier J, Forrey AW, O'Neill MA, et al: Pharmacokinetics of amikacin in patients with normal or impaired renal function. *J Infect Dis* 134:S323-S330, 1976.
- Black RE, Lau WK, Weinstein RJ, et al: Ototoxicity of amikacin. *Antimicrob Agents Chemother* 9:956-961, 1976.
- Feld R, Valdivieso M, Bodey GP, et al: Comparison of amikacin and tobramycin in the treatment of infections in patients with cancer. *J Infect Dis* 135:61-66, 1977.
- Smith CR, Baughman KL, Edward CQ, et al: Controlled comparison of amikacin and gentamicin. *NEJM* 296:349-353, 1977.
- Tally FP, Louie TJ, Weinstein WM, et al: Amikacin therapy for severe gram-negative sepsis: emphasis on infections with gentamicin-resistant organisms. *Ann Intern Med* 83:484-488, 1975.
- Meyer RD, Lewis RP, Carmalt ED, et al: Amikacin therapy for serious gram-negative bacillary infections. *Ann Intern Med* 33:790-800, 1975.
- Parry MF, Neu HC: Ticarcillin for treatment of serious infections with gram-negative bacteria. *J Infect Dis* 134:476-485, 1976.
- Neu HC, Garvey GJ: Comparative *in vitro* activity and clinical pharmacology of ticarcillin and carbenicillin. *Antimicrob Agents Chemother* 8:457-462, 1975.
- Parry MF, Neu HC: Pharmacokinetics of ticarcillin in patients with abnormal renal function. *J Infect Dis* 133:46-49, 1976.
- Ervin FR, Bullock WE: Clinical and pharmacologic studies of ticarcillin in gram-negative infections. *Antimicrob Agents Chemother* 9:94-101, 1976.
- Parry MF, Neu HC, Merlino M, et al: Treatment of pulmonary infections in patients with cystic fibrosis: A comparative study of ticarcillin and gentamicin. *J Pediatr* 90:144-148, 1977.



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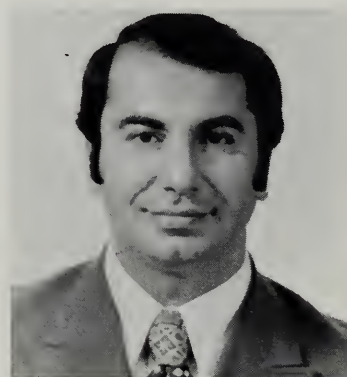
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New Members



Robert Louis Hickok, Jr., M.D., is a 1970 graduate of the University of Pennsylvania School of Medicine. His internship and residency were served at the Hospital of the University of Pennsylvania. Doctor Hickok's office is at 2323 Pennsylvania Avenue, Wilmington, where he practices obstetrics and gynecology. He lives in Wilmington with his wife and two children. Doctor Hickok enjoys hunting and fishing.

Ali Kalamchi, M.D., graduated from Baghdad Medical School, Baghdad, Iraq, in 1968. He interned at Republic Teaching Hospital, Baghdad, Iraq, and Jersey City Medical Center, Jersey City, New Jersey. His residency was spent at St. Michael's Hospital, Toronto, Canada. Doctor Kalamchi specializes in pediatric orthopaedics and is practicing at the A. I. duPont Institute. He lives in Wilmington.

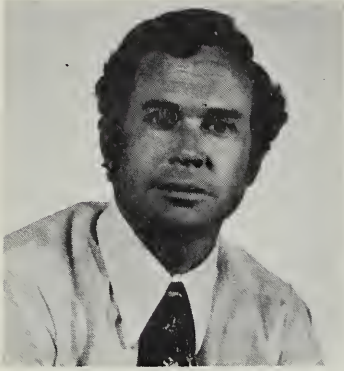


Edward R. Sobel, D.O., is a 1973 graduate of the Kansas City College of Osteopathic Medicine. He served his internship at Parkview Hospital, Philadelphia, Pennsylvania. He is a family practitioner currently practicing at 1100 S. Broom Street, Wilmington. Doctor Sobel, his wife, and two children live in Wilmington. His hobbies include gardening and tropical fish.

Barry M. Kotler, M.D., is a graduate of Jefferson Medical College, '61. He interned at Lackland Air Force Base Hospital, Texas, specializing in family and occupational medicine. Doctor Kotler previously practiced in New Brunswick, New Jersey. He is currently practicing at 200 Kings Highway, Milford. He lives in Dover with his wife and three children. Doctor Kotler is a tennis buff and enjoys concert music, cooking, woodworking, and motorcycling.



New Members



Richard A. Crocco, M.D., graduated from Ohio State Medical College in 1963. His internship and residency were served at Georgetown University Hospital, Washington, D.C. Before coming to Delaware, Doctor Crocco directed a family therapy unit at Thomas Jefferson University, Philadelphia, Pennsylvania. He now practices psychiatry at 325 E. Main Street, Newark. Doctor and Mrs. Crocco live in Newark with their three children. Doctor Crocco enjoys golfing and teaching family theory and psychotherapy.

Lazarus M. Kirifides, D.O., graduated from the Philadelphia College of Osteopathic Medicine in 1957. He served his internship and residency at Riverside Hospital. Doctor Kirifides is an obstetrician-gynecologist practicing at 1320 Philadelphia Pike, Wilmington. He lives with his wife and three children in Wilmington. Doctor Kirifides is an artist who enjoys collecting paintings and stamps.



A 1967 graduate of Loma Linda University School of Medicine, Edward Dale LaTonn, M.D., is a new family practice physician in Wilmington. Doctor LaTonn practiced medicine in California and Minnesota before coming to Wilmington. He, his wife, and daughter live in Newark. Doctor LaTonn enjoys boating and fishing.

Elias Mamberg, M.D., an obstetrician-gynecologist practicing at 1401 Pennsylvania Avenue, Wilmington, is a 1972 graduate of Universidad Autonoma de Guadalajara. He interned at the Moncton Hospital, Canada, and served his residency at the Wilmington Medical Center. He, his wife, and two children live in suburban Wilmington. Doctor Mamberg enjoys tennis, bicycling, swimming, and being with his family.



MOTIVATIONAL AND ORGANIZATIONAL BEHAVIOR THEORIES APPLICABLE TO MEDICAL PRACTICES

LEIF C. BECK, LL.B., C.P.B.C.
VASILIOS J. KALOGREDIS, J.D.

There have been many studies and publications regarding people and their behavior in situations such as their places of employment.

There is no theoretical solution that fits all organizational and motivational problems, however. In this article, we will outline some theory and assumptions about individuals which can be applied and be helpful in the administration and management of medical office personnel.

Needs—Motivation Theory

Abraham Maslow is one of the more well-known experts in the field of motivation. He believes in a hierarchy of human needs which provide the basis for motivation underlying the activities of individuals.

He postulated that there are successive levels of human needs which people are capable of feeling and that the need which is prevalent or dominant at a particular time will govern the effort a person will be willing to exert in order to achieve a given objective. Once a need has been satisfied, it can no longer serve as an effective motivator. However, as one set of needs is satisfied, another set emerges that then serves as the dominant motivator of one's behavior. These five needs emerge in a given order.

1. Physiological Needs

These include the need for food, water, air, rest, shelter, and exercise. If an individual is hungry, he will expend his last ounce of energy to obtain food. He would therefore be strongly motivated to obtain things which would help satisfy this need. Once this need has been satisfied, he is no longer motivated to expend much

effort in obtaining more food or water. This illustrates a key concept of Maslow's motivational theories: a satisfied need is not a strong motivator of human behavior.

2. Safety or Security Need

This involves the need to feel both physically and emotionally secure, to have freedom from both deprivation and threat. This includes a feeling by individuals that they are getting "the fairest possible break." Once the physiological needs have been satisfied and therefore are no longer motivating, this safety or security need becomes the primary motivator.

3. Social Needs

This involves a feeling of belonging to a group and association with fellows. It also involves being accepted by peers and of giving and receiving friendship and love.

4. Ego Needs

These are broken down into two categories. First is the need for self-esteem, self-respect, self-confidence, autonomy, competence, and knowledge (basically, a feeling that one matters as an individual). The second part of the ego needs involve reputation, status, recognition, appreciation, and the merited respect and praise of fellows.

5. Self-Fulfillment Needs

This is the highest level in Maslow's hierarchy of needs. It is operative only when all of the four lower level needs have been satisfied. It involves many things. It primarily involves allowing one to realize his or her own highest potential, with continued growth and self-development.

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Since this highest level is the real goal one should seek for all of his employees, we will dwell more on what a self-actualizer is.

A simple definition is that a self-actualizer is a person whose lower-level needs have been met, or are being met, and who is thus self-motivated. In other words, this individual is motivated from within by his or her need for continued self-development and the fulfillment of his or her potential as a human being.

What are some of the characteristics of such an individual? Such a person accepts himself as he is. This person knows his strengths and builds upon them. He also knows his mistakes and failures. He values and accepts them for what they can teach him. In addition, this person recognizes that he is human, less than perfect, and therefore takes advantage of constructive criticism and suggestions.

A self-actualizer is realistic, aware of his capabilities as well as those of others. This type of person knows what can be done.

He is also tolerant of uncertainty and change. Not being afraid of new ideas and conditions, such an individual is willing to be innovative and to function within new parameters. In addition, other people are accepted as they are, and there is a willingness to work wholeheartedly and closely with new personnel. Such a person is not afraid to make independent decisions.

The self-actualizer is committed to work and goes beyond the call of duty because of a belief in what is being done.

Lastly, the self-actualizer is appreciative and grateful. He has a genuine interest in others. In addition, such an individual is appreciative of the multi-faceted nature of life and its infinite

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richness. Furthermore, this individual is appreciative and grateful for the God-given opportunity to be, to feel, to know, to do, to create, and to become.

Operating under the "hierarchy of needs" approach, the function of a medical office personnel manager or administrator becomes a process, not of doing anything to people to motivate them, but rather of finding out which level of need is felt most strongly by each person. The next step involves trying to provide conditions which will enable each individual to satisfy his strongest need, while at the same time satisfying the organization's need for performance from the individual. To sum up, organizational leadership is not a manipulative but a facilitative process.

Theory X

Dr. Douglas McGregor is another well-respected expert in the field of motivation and organizational behavior.

He states that the conventional conception of organizational leadership's role in directing human energy towards organizational goals has been based on at least three propositions or assumptions about human behavior with which he disagrees. This set of assumptions forms what he has called "Theory X." These three assumptions are as follows:

1. Average human beings have an inherent dislike of work and will avoid it if they can.
2. Because of people's dislike of work they must be coerced, controlled, directed, manipulated, or threatened with punishment in order to get them to put forth satisfactory effort towards accomplishing the organization's objectives.
3. The average person prefers to be directed and wishes to avoid any responsibility. The average individual has little or no ambition and wants security above all.

Theory X had long been the accepted approach to motivation and productivity. In McGregor's mind, management has had some confusing consequences with true cause and effect. Theory X merely demonstrates what happens to people's

productivity as a consequence of management's application of the philosophy espoused by Theory X. The factors underlying motivation (cause) and the evidence of motivated productivity (effect) were ignored in Theory X.

McGregor has drawn from Maslow's needs-motivation theory and his studies on motivation. He notes that for all practical purposes, the physiological and safety/security needs of people have ceased to exist in our present society. Often-times managers and physicians wonder why their employees are not more productive. Their employees receive good wages, and have excellent fringe benefits, good working conditions, and steady employment. Yet in many instances individuals do not seem to be willing to put forth more than minimum effort.

This is answered by the fact that the physiological and safety needs have been well provided for. In the light of that, the motivational emphasis has changed in today's society to the social and in some instances to the ego need level. Unless work provides an opportunity to satisfy these higher level needs, employees will feel deprived and their behavior will be a reflection of this feeling.

If management continues to focus attention on physiological needs, people will make consistent and unreasonable demands for more financial rewards. This is because the money is more important than ever in order to buy the material goods and services which can provide limited satisfaction of some of the thwarted higher needs. In reality money has only limited value in satisfying most of the higher level needs; it can become the focal point of interest, however, if it is the only means available of obtaining any satisfaction.

A key thing to keep in mind is that management cannot provide self-respect or self-fulfillment. It can create conditions to allow and encourage people to seek such satisfactions for themselves; however, too often conditions are provided that thwart such improvements.

Theory Y

Under today's social conditions, McGregor reasons that a different set of assumptions is

needed in order to manage well. He has suggested a more humanistic approach and entitled it "Theory Y."

Theory Y is based on the following assumptions:

1. The expenditure of physical and mental effort in work is as natural as rest and play.
2. People are not by nature passive or resistant to organizational needs. In some cases people have become so as a result of past organizational experiences.
3. The motivation, the potential for development, the capacity for assuming responsibility, and the readiness to direct behavior towards organizational goals are present in all people. Management does not put them there. In light of that, a manager or supervisor is responsible for making it possible for individuals to recognize and develop those human characteristics for themselves.
4. The essential task of a leader is to arrange

conditions within the practice so that people can achieve their own goals best by directing their efforts toward organizational objectives.

It is really a process of creating opportunities, releasing potential, removing obstacles, encouraging growth, and providing guidance.

As is obvious, Theory X represents a static and somewhat pessimistic view of people. The assumptions of Theory Y are much more optimistic and humanistic, reflecting a feeling of unlimited potential for personal and organizational growth. Theory Y is more dynamic and amenable to the changing nature of medical practice's needs as well as of individuals.

Conclusion

Most of the above, although theoretical, is "real." A knowledge of such concepts can help physicians and managers better leaders of personnel in the medical practice setting.

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PROCEEDINGS OF THE HOUSE OF DELEGATES, 1977

MEDICAL SOCIETY OF DELAWARE

RESOLUTIONS

The following resolutions were considered at the Annual Meeting of the House of Delegates of the Medical Society of Delaware.

Resolution No. 77-1

Whereas, 24 Delaware Code, §1763 states that "Every physician attending or treating epilepsy shall report within 1 week to the Division of Motor Vehicles the names, ages and addresses of all persons treated as cases of epilepsy"; and

Whereas, 21 Delaware Code, §2707 states that reinstatement of driving privileges is dependent upon certification by two physicians that the epilepsy is under adequate control; and

Whereas, the fear of revocation of driving privileges leads to the concealment of seizures which then go untreated; and

Whereas, the desire to obtain certification leads to the same concealment so that the patient falsifies his history, claims he is not having seizures, and not only obtains the certification (and with it his driving privileges) but also fails to receive appropriate surveillance and medication; and

Whereas, instead of decreasing the likelihood that patients with inadequately controlled seizures are driving, this increases the chances that patients with inadequately managed seizure disorders are driving; therefore, be it

Resolved, that the Delaware Code be revised so as to eliminate all obligation to report patients with epilepsy to the Division of Motor Vehicles.

MARTIN GIBBS, M.D.

Report of the Reference Committee

The Reference Committee recommended that the Resolved be amended by the addition of the following words and that the resolution then be adopted: "; however, a physician may report to the Motor Vehicle Division any patient who, in his opinion, has a seizure or sinkable condition inadequately controlled to permit his safe operation of a motor vehicle, and said reporting physician will be immune to civil and criminal actions."

The House did not adopt the resolution.

Resolution No. 77-2

Whereas, the 1976 House of Delegates approved evidence of continuing medical education as a requirement for membership in the Medical Society of Delaware; and

Whereas, the House directed that steps be taken to implement this program; now therefore be it

Resolved, that the by-laws be amended as follows:

Article III—Membership

Section 7

Good Standing

Add a new paragraph as follows:

- (d) If he has not met the continuation study requirements as prescribed by the Continuing Education and Certification Committee of the Medical Society of Delaware.

Article IV—Component Societies

Section 4

Limitations

Add a new paragraph as follows:

- (e) A component society will suspend a member for failure to comply with the continuation study requirements as prescribed by the Continuing Education and Certification Committee of the Medical Society of Delaware until such time as such post-graduate study credit is achieved.

CONTINUING EDUCATION AND
CERTIFICATION COMMITTEE
BOARD OF TRUSTEES

Report of the Reference Committee

The Reference Committee recommended adoption of this resolution.

The House amended the (e) under Article IV, Section 4, by changing the word *will* to *may*. The resolution was then adopted.

Resolution No. 77-3

Whereas, the by-laws of the New Castle County Medical Society provide a new category of affiliate membership; and

Whereas, no provision exists for this new category of members to belong to the Medical Society of Delaware; now therefore be it

Resolved, that the by-laws be amended as follows:

Article III—Membership

Section 5

Affiliate Members

Affiliate members may be (a) medical students, interns, and residents in an accredited education program recognized by this Society or (b) *former active or associate members of this Society who no longer practice or reside in Delaware.** Affiliate members shall not be entitled to vote or hold office.

JOHN LEVINSON, M.D.

Report of the Reference Committee

The Reference Committee recommended amendment of this resolution by inserting the word *either* after the word *who* and then adoption.

The House did not adopt the resolution.

*Italicized words are additions to the by-laws.

Resolution No. 77-4

Whereas, the total cost of individual blood tests ordered sometimes exceeds the cost of these tests if done as part of a multiphasic laboratory procedure; now therefore be it

Resolved, that when multiple laboratory testing (bench method) is done in a physician's office not on an emergency basis, it is recommended that more costly methods of individual tests be abandoned and full use of multi-screening methods be used to reduce patient cost.

BOARD OF TRUSTEES

Report of the Reference Committee

The Reference Committee submitted a substitute *Resolved* as follows: "That when multiple laboratory tests (bench method) are not on an emergency basis, it is recommended that more costly methods of individual tests be abandoned and full use of equivalent quality multi-screening methods available in the community be used to reduce patient cost." The Committee then recommended adoption of the resolution.

The House adopted the substitute resolution.

Resolution No. 77-5

Whereas, it is imperative that the support of the medical profession voiced through the American Medical Association on the national level be as vigorous as possible; and

Whereas, those physicians who do not pay dues, benefit equally from AMA efforts in behalf of organized medicine as do dues-paying members; and

Whereas, it is necessary for us to present a unified front in the socio-economic environment in which we exist today; now therefore be it

Resolved, that all members of the Medical Society of Delaware be encouraged to join the American Medical Association; and be it further

Resolved, that the President appoint a committee to direct a statewide membership drive.

BOARD OF TRUSTEES

Report of the Reference Committee

The Reference Committee recommended adoption of this resolution.

The House adopted the resolution.

Resolution No. 77-6

Whereas, there is a proliferation of health planning at the county, state, and national levels; and

Whereas, such health planning profoundly affects all physicians in their daily practice of medicine; and

Whereas, it behooves the Medical Society of Delaware to monitor all legislative and bureaucratic changes in the laws, rules, and regulations concerning health planning; now therefore be it



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Resolved, that the Medical Society of Delaware establish a new committee whose membership shall include physician representatives from the Health Service Area, a member of the Public Laws Committee and the Board of Trustees of the Society, and a physician member of the Governor's Coordinating Council. The Committee shall monitor development in health planning at local, state, and national levels; gather information regarding legislative and bureaucratic changes in the laws, rules, and regulations concerning health planning; and disseminate such information to the House of Delegates, the Board of Trustees, and appropriate Society committees. The Committee may recommend action to the Society's governing bodies.

BOARD OF TRUSTEES

Report of the Reference Committee

The Reference Committee recommended adoption of the resolution.

The House adopted the resolution.

Resolution No. 77-7

Whereas, the spirit of justice is being thwarted by the fact that some doctors pose and testify as experts in medical fields in which they lack expertise; and

Whereas, in addition, it serves as a source of embarrassment to the medical profession as a whole; now therefore be it

Resolved, that the Medical Society of Delaware go on record as declaring it unethical if any member of the Society testifies as an expert witness in any matter in litigation before the courts or quasi judicial bodies of Delaware or the U.S. if such a member does not possess basic educational and professional knowledge as a general foundation for his testimony, does not have current personal experience and practical familiarity with the problems that are being considered, and has not recently actively engaged in the practice of the medical subject under consideration; and be it further

Resolved, that after due process the penalty for so testifying could be expulsion from his/her county medical society and the Medical Society of Delaware; and be it further

Resolved, that the by-laws be so amended to reflect the spirit of this resolution.

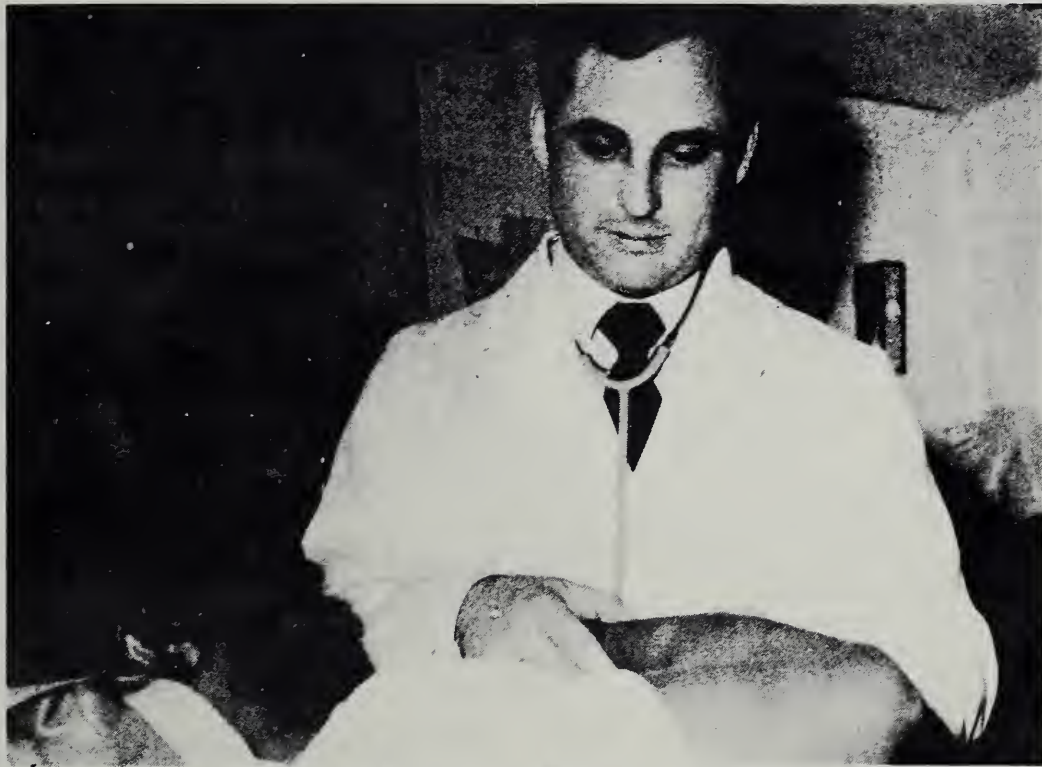
BOARD OF TRUSTEES

Report of the Reference Committee

The Reference Committee recommended that the resolution be rejected.

The House did not adopt the resolution.

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Resolution No. 77-8

Whereas, the endorsement of specific legislation drafted by the AMA and introduced into the Congress as S.218 and H.R.1818—the Comprehensive Health Care Insurance Act of 1977—provides the most effective method of articulating AMA support of health insurance through the private sector in the formulation of a national health insurance policy by Congress; and

Whereas, the AMA proposal affords a viable solution to the problem of providing quality health and medical care to everyone at a cost the nation can afford; and

Whereas, the AMA approach would accomplish this goal with an absolute minimum of federal involvement in funding; and

Whereas, in poll after poll the public indicates that it overwhelmingly prefers a national health insurance program that is free of federal control; and

Whereas, the AMA proposal would preserve the private sector thrust of medical and health care and its financing by building upon the highly successful existing system of private health insurance; and

Whereas, the AMA position maintains continued total opposition to nationalization of the medical pro-

fession and would honor the profession's wants and needs while preserving professional freedom; now therefore be it

Resolved, that the Medical Society of Delaware believes that the 17 principles as enunciated by the AMA are essential in any form of national health insurance; and be it further

Resolved, that the Medical Society of Delaware endorses the AMA's participation in the national health insurance debate and its support of health insurance through the private sector, through the introduction of S.218 and H.R.1818.

(A brief summary of the AMA National Health Insurance Proposal was presented to the Reference Committee.)

Report of the Reference Committee

The Reference Committee recommended adoption of this resolution.

The House adopted the resolution.

Resolution No. 77-9

Whereas, in Delaware the Blood Bank of Delaware Blood Assurance Program is firmly based on individual responsibility; and

Whereas, this Delaware Program as the largest such plan in the United States has more than adequately met Delaware's needs for blood donors; and

Whereas, any weakening of the concept of individual responsibility would throw blood donor procurement into a state of chaos; and

Whereas, for approximately 15 years the American Red Cross and the American Association of Blood Banks have been cooperating partners in a National Clearinghouse Program designed to facilitate the movement of blood and credit for blood donation throughout the country; and

Whereas, this program allows a patient in one part of the country to receive credit for the voluntary donation of blood by a relative or a friend in another part of the country; and

Whereas, the Clearinghouse has been the single mechanism for national control of blood inventories, arranging inter-bloodbank borrowing and lending, and alleviating type-specific shortages reported in various parts of the country; and

Whereas, since its inception the Clearinghouse has handled the transfer of more than 4 million blood replacement credits resulting in an estimated ninety-seven million dollar financial saving in blood costs for patients receiving blood transfusions, which is of special significance to chronic blood users, such as

hemophiliacs, in whose name donated blood offsets transfusion expenses; and

Whereas, the unilateral termination of the Clearinghouse agreement by the American Red Cross effective October 19, 1976, is destined to cause confusion among hospitals and a potential hardship to transfusion patients; now therefore be it

Resolved, that the Medical Society of Delaware declare the withdrawal of the American Red Cross from the National Blood Clearinghouse Program to be inexpedient and not in the best interests of the public; and be it further

Resolved, that the Medical Society of Delaware support the premise of a non-replacement or deposit fee as an effective incentive for blood replacement and as a method of financial saving for patients when blood is replaced by friends or relatives; and be it further

Resolved, that the Medical Society of Delaware call on the American Blood Commission to urge the leaders of the American Red Cross to reconsider and endorse the National Blood Clearinghouse Program.

BOARD OF TRUSTEES

Report of the Reference Committee

The Reference Committee recommended addition of the words *in Delaware* in the third Whereas after *blood donor procurement* and then adoption of the resolution.

The House adopted the resolution.

Resolution No. 77-10

Whereas, transplantation of kidneys is now performed with routine clinical confidence; and

Whereas, it is easier to graft a kidney than to procure one (three-year survival rate for cadaver kidneys runs better than 50%); and

Whereas, the ideal cadaver donor will be in the prime of life dying from irreversible brain damage but with his other organs disease-free; and

Whereas, organ preservation can preserve a viable kidney up to 72 hours; now therefore be it

Resolved, that legislation for the definition of legal death as set forth in S.B. 352 be approved by the Medical Society of Delaware.

JOSEPH F. HUGHES, M.D.

Report of the Reference Committee

The Reference Committee recommended adoption of a substitute resolution as follows:

Whereas, it is deemed desirable to have a definition

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of legal death incorporating the absence of brain function; now therefore be it

Resolved, that legislation for the definition of legal death as set forth in S.B. 352 be actively supported by the Medical Society of Delaware.

The House adopted the substitute resolution.

Resolution No. 77-11

Whereas, our frequent professional medical fee structure in Delaware has developed over many years as the result of tradition, historical reference, emotional reasoning, political, governmental and industrial interference, and not just on the basis of worth, risk, and cost analysis; and

Whereas, the fee structure at times is so imbalanced that the community has difficulty in understanding it; and

Whereas, our own profession at times has difficulty in defending it; and

Whereas, recent action of the Medical Society of Delaware in agreeing to a limitation of the movement of the 90th percentile to 6% at best was a holding type action, which has served the Delaware community and our profession well on a one-time basis; and

Whereas, such action does not correct inequities; now therefore be it

Resolved, that the Medical Society of Delaware through appropriate committees in concert with the Board of Trustees undertake the responsibility of reviewing all fees, in all procedures, for the purpose of establishing a fair, understandable, and definable fee structure as a guide for our professional use by January 1, 1979.

I. J. TIKELLIS, M.D.

Report of the Reference Committee

The Reference Committee recommended adoption after changing the Resolved to read as follows: "That the Medical Society of Delaware through appropriate committees in concert with the Board of Trustees undertake the responsibility of reviewing fees, for the purpose of establishing a fair, understandable and definable guide for our professional use by January 1, 1979."

The House did not adopt the resolution as amended.

Resolution No. 77-12

Whereas, our By-laws are currently outdated; and

Whereas, our By-laws have not kept pace with present activities and procedures; therefore be it

Resolved, that a Constitution and By-laws Com-

mittee be made a Standing Committee; and be it further

Resolved, that the Constitution and By-laws Committee be directed to update the current By-laws on a timely basis so that they may be presented at the next Annual Meeting for approval and publication.

C. E. GRAYBEAL, M.D.

Report of the Reference Committee

The Reference Committee recommended adoption of the resolution.

The House adopted the resolution.

Resolution No. 77-13

Whereas, our present By-laws make it unduly difficult to amend these same By-laws at the regular session of the House of Delegates; and

Whereas, it has become important for the By-laws to be kept current and appropriate to today's needs; now therefore be it

Resolved, that Article XV Section I be deleted in its entirety, and the following new Section 1 be adopted in its stead:

ARTICLE XV

AMENDMENTS

Section 1

PROCEDURE

These By-laws may be amended on the approval of two-thirds (2/3) of the members of the House of Delegates present and voting. A proposed amendment shall not be acted on, however, until it has been considered and reported on by the standing committee on Constitution and By-laws.

C. E. GRAYBEAL, M.D.

Report of the Reference Committee

The Reference Committee recommended rejection of the resolution.

The House did not adopt the resolution.

Resolution No. 77-14

Whereas, there is a growing number of physicians in the Newark area; and

Whereas, the physicians in the Newark area have banded together to form a Newark Medical Society because of their common interests and problems; and

Whereas, the Kent and Sussex County Medical Societies are staffed by the Medical Society of Delaware; and

Whereas, this staffing could be extended to the Newark Medical Society if it were a component of the Medical Society of Delaware; now therefore be it

Resolved, that members of the Newark Medical Society be encouraged to seek to become a component Society of the Medical Society of Delaware.

RHOSLYN J. BISHOFF, M.D.

Report of the Reference Committee

The Reference Committee recommended that the resolution be rejected.

The House did not adopt the resolution.

Resolution No. 77-15

Whereas, doctors are not always in attendance and physically cannot always be in attendance when emergency care is needed; and

Whereas, nurse assistants and physicians' assis-

tants are already giving invasive therapy; and

Whereas, protocols exist to cover these above situations; and

Whereas, questions have been raised concerning the limits of the physician's liability when the protocols are enacted or carried out; now therefore be it

Resolved, that an ad hoc committee be appointed to establish the legal boundaries for all existing and future medical and surgical protocols.

RHOSLYN J. BISHOFF, M.D.

Report of the Reference Committee

The Reference Committee recommended that the *Resolved* be changed to read, "That an ad hoc committee be appointed to investigate the legal boundaries for all existing and future medical and surgical protocols," and that the resolution then be adopted.

The House adopted the resolution as changed.

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Book Reviews

MANUAL OF ENDOCRINE DIAGNOSIS by Stanley G. Korenman, M.D., Daryl K. Granner, M.D., Barry M. Sherman, M.D., Robert S. Gardner, M.D., Diagnostic Publishing Company, Inc, Iowa City, Iowa, 1974. 122 pp. Illus. Price \$6.50 paperback.

Since the field of testing for endocrine hyperfunction, hypofunction, or dysfunction has expanded so enormously and continually since the development of radioimmunoassay techniques, a manual of endocrine testing almost has to be paperback to have any possibility of currency. This book lists some tests still generally unavailable. However, other tests, such as the propranolol and exercise screening tests for growth hormone insufficiency, are not mentioned.

Nevertheless, the information in this manual is hard to come by; hardback texts are not apt to give sufficient details for the clinical performance of tests which involve physiologic manipulation. This book is as good as any manual on the subject I have seen.

Some of the omissions which I noted may be omissions of deliberate prejudice. Perhaps the endocrinologists at the University of Iowa as a group disapprove of hypertonic saline tests (Hickey-Hare) for diabetes insipidus; nevertheless, for completeness, directions for its performance should have been included.

BERNADINE Z. PAULSHOCK, M.D.

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CLINICAL METHODS: THE HISTORY, PHYSICAL AND LABORATORY EXAMINATIONS vol 1 and 2 by H. Kenneth Walker, W. Dallas Hall, and J. Willis Hurst, Butterworths, Woburn, Massachusetts, 1976. 1,098 pp. Price \$28.00 spiral bound.

This two-volume text appears as a welcome addition to the reference and review literature which is presently threatening to inundate most physicians. It has been well edited and consists primarily of very short descriptions of most of

the medical problems that the general physician may be expected to encounter. (The primary exception to the shortness of the majority of the medical problems appears in the sections dealing with the cardiovascular system, in particular, the EKG.)

Each small "chapter" consists of a brief definition, technique, a small amount of background information, and clinical significance. In these brief sentences is encompassed a summary of a single medical topic, for extremely rapid review. The major defect is the lack of a brief note regarding the treatment of the particular problem.

Of particular interest are the sections dealing with interpretation of single laboratory tests, a refreshing reintroduction to some basic physiological medicine.

One minor flaw may be found on the first attempt to use the table of contents. A mix-up in chapter enumeration may cause some confusion—the chapter titles are mislabeled in Volume I but are correct in Volume II.

These volumes are well recommended as distinctive review texts, with references, to all practicing physicians.

SELF-ASSESSMENT IN CLINICAL CARDIOLOGY II edited by Michael Gordon, M.D. Year Book Medical Publishers, Chicago, 1976. 349 pp. Illus. Price \$11.95 paperback.

This brief text of cardiology is based on the clinical cardiology conference occurring annually at the University of Miami. A large number of authors have contributed to the book with individual chapters. The book covers a broad range of topics from the basic principles of bedside diagnosis (including the standard review of anatomy and physiology) through a core curriculum in electrocardiography and practical drug therapy, to advances in electrophysiology, the hemodynamics of cardiogenic shock, coronary

Book Reviews

artery disease, hypertension, and a well-placed section on echocardiography. The total is related to clinical patient care.

One truly outstanding feature of this book is the section devoted to self-assessment. This comprises almost half the entire text and is quite comprehensive, being based on the material covered in earlier sections. Each chapter in the book has a few selected references.

The one primary facet of this text that most readers are likely to look on with disfavor is the size of the print: it is "exceeding small." One other small defect, which may or may not be one according to taste, is that the book is paper-bound. After but a short while my copy has already become a bit dog-eared. Naturally, harder covers require the expenditure of proportionately larger sums, and the more penurious of us may be somewhat unwilling to lay out the required increase. But surely a text that may prove itself worthy of frequent usage deserves less fragile bindery.

ETHEN G. FLAKS, M.D.



DR. FRANK'S NO-AGING DIET by Benjamin S. Frank, M.D., The Dial Press, New York, 1976. Price \$7.95.

The jacket cover pretty much sums it up . . . "Eat and Grow Younger with the 'No Aging Diet.'"

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you think there is something fishy about this, then load up on sardines—the highest RNA content of any food is in canned sardines. There are recipes such as sardine "hero," sardine pizza, cardine empanadas, along with other recipes for high-RNA-content legumes. Fascinating, to say the least, and impossible to critique. If you decide to try it, let me suggest the fine Empress Brisling sardines. These are the most palatable of the lot. And, I wouldn't suggest the diet immediately before office hours.

PETER R. COGGINS, M.D.



PSYCHOPHARMACOLOGY IN THE PRACTICE OF MEDICINE by Murray E. Jarvik, M.D., Ph.D., Appleton-Century-Crofts, New York, 1977. 553 pp. Price \$20.50.

This book was written for primary care physicians. The immense subject requires a rather cursory treatment of some of the topics, but on the whole it is very well done. It is divided into four main sections, with introductions to each chapter. There are some three dozen contributing authors. The first section includes an overview of psychopharmacology in medical practice, which could have been excluded without major detriment. The second section, which deals with experimental psychopharmacology, includes some good material. The chapter on placebos is noteworthy; those on sleep and the distribution of drugs to the brain are not done as well as the others.

The third section of the book, clinical psychopharmacology, is much better. There is a good chapter on non-prescription drugs, and the sections on antidepressants, major tranquilizers, narcotics, and lithium carbonate are all excellent. This part of the book alone makes it worth buying. The fourth section concerns drugs of dependence. The chapters on alcohol and nicotine and tobacco are particularly good.

In summary, this book attempts to present a massive subject in a manageable form for the primary care physician. It does a good job, especially concerning the topics of greatest clinical relevance.

ROBERT H. HALL, M.D.

In Brief

Speakers on "Ask the Doctor"

Speakers for February 1978 on the Tuesday radio program (11:05 a.m., WDEL) produced by the Medical Society of Delaware are: February 7, *Bruce E. Matthews, D.D.S.*, Children's Dental Health; February 14, *E. Wayne Martz, M.D.*, Heart Attack: Cause, Cure and Prevention; February 21, *Lawrence Katzenstein, M.D.*, Loss of Hair; February 28, *L. William Ferris, M.D.*, Urinary Tract Infections.

CLINICAL NOTICES AND MEETINGS

30th Anniversary Symposium

The American Heart Association and the National Heart, Lung, and Blood Institute will celebrate their 30th anniversary, February 8-9, at the Washington Hilton Hotel, Washington, D.C. and the Jack Masur Auditorium at the National Institutes of Health in Bethesda, Maryland. The program on February 8 will be a Report to the Nation on "Progress Toward Prevention of Cardiovascular Disease." On February 9 the program will be directed to physicians and scientists with a series of presentations by eminent scientists on "Current Horizons in Atherosclerosis and Hypertension." Transportation services will be provided between the Washington Hilton Hotel and the National Institutes of Health in Bethesda, Maryland for the Symposium on February 9. For information contact: Ms. Janis L. Aldridge, AHA/NHLBI 30th Anniversary, 1501 Wilson Boulevard, Suite 600, Arlington, Virginia 22209. Telephone: (703) 527-4500.

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In Brief

Cancer Research Symposium

The University of Texas System Cancer Center M. D. Anderson Hospital and Tumor Institute, The National Cancer Institute, American Cancer Society, Texas Division, Inc., and the University of Texas Health Science Center Graduate School of Biomedical Sciences will present the 31st M. D. Anderson Annual Symposium on Fundamental Cancer Research, "CARCINOGENS: IDENTIFICATION AND MECHANICS OF ACTION, March 1-3 at the Shamrock Hilton Hotel, Houston, Texas. The Main areas of discussion will focus on identifying environmental carcinogens and the mechanisms involved in transforming normal cells to malignant cells. To register, write: Symposium Registration, University of Texas System Cancer Center M. D. Anderson Hospital and Tumor Institute, Texas Medical Center, Houston, Texas 77030.

ACP Courses

The American College of Physicians will sponsor the following courses which may be used to fulfill Category I requirements for the AMA's Physician's Recognition Award. For information contact: Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, PA 19104.

PRACTICAL MANAGEMENT OF PULMONARY DISEASES, Temple, Texas, March 1-3.
DIAGNOSIS, TREATMENT, AND PREVENTION OF GENETIC DISEASE, Palm Springs, California, March 6-8.

RECENT ADVANCES IN NEURO-ENDOCRINOLOGY, Montreal, Canada, March 6-8.

RECENT ADVANCES IN INTERNAL MEDICINE, Galveston, Texas, March 20-22.

CURRENT CONCEPTS IN RENAL DISEASE AND ELECTROLYTE DISORDERS, New Haven, Connecticut, March 20-24.

CLINICAL ENDOCRINOLOGY, Nashville, Tennessee, March 22-24.

CLINICAL RECOGNITION AND MANAGEMENT OF HEART DISEASE, Tucson, Arizona, March 23-25.

DIAGNOSTIC AND THERAPEUTIC ADVANCES IN GASTROENTEROLOGY, Rochester, Minnesota, March 29-31.

Detection and Treatment of Breast Cancer

The 17th ANNUAL NATIONAL CONFERENCE ON THE DETECTION AND TREATMENT OF BREAST CANCER will be held March 6-9, San Francisco, California. The Conference, sponsored and arranged by the American College of Radiology (ACR), is co-sponsored by the College of American Pathologists, and the Educational Foundation of the Society of Plastic and Reconstructive Surgeons, in cooperation with the American College of Obstetricians and Gynecologists. The conference is supported by the American Cancer Society and ACR. Topics to be covered are: Diagnosis and Treatment; Pathology; Workshops in Xeromammography; Film Mammography; and Thermography. The meeting has been approved for 29 hours of Category I credit, and is also approved by the American College of Obstetricians and Gynecologists for 18 cognates plus 2 cognates for each workshop. For information contact: Breast Cancer Conference, ACR, 6900 Wisconsin Avenue, Chevy Chase, MD 20015.

Howard University Courses

Howard University College of Medicine, along with various co-sponsors, will present the following courses:

March 13, CHARLES R. DREW MEMORIAL LECTURE AND SEMINAR, 9 a.m. to 3 p.m., at Howard University Hospital. For information contact: LaSalle D. Leffall, Jr., M.D., (202) 745-1441.

March 14, BURKE SYPHAX DAY, 9 a.m. to 3 p.m. at Howard University Hospital. Co-sponsored by Howard University College of Medicine Department of Surgery. For information contact: LaSalle D. Leffall, Jr., M.D., (202) 745-1441.

March 22, CURRENT MANAGEMENT OF LEUKEMIAS AND LYMPHOMAS, 9 a.m. to 4 p.m., at Howard University Hospital. Co-sponsored by Howard University Cancer Research Center, Department of Oncology, and Office of Continuing Medical Education. For information contact: Linda Green, M.D., (202) 745-1406.

DAFP Annual Meeting

The Delaware Academy of Family Physicians will hold its Annual Meeting and 26th Annual Scientific Assembly, March 7 and 11, at the Delaware Academy of Medicine. The topic for the scientific session is "FOOD FOR THOUGHT: FOOD FOR HEALTH." Spouses are welcome. For further information contact: Ms. Anne Shane Bader, DAFP, 1925 Lovering Avenue, Wilmington, Delaware 19806. Telephone: (302) 658-7596.

Models of Therapy

The Family Therapy Training Center of the Philadelphia Child Guidance Clinic will present MODELS OF THERAPY, March 9-11, from 9:30 a.m.-4:30 p.m. on March 9 and 10, and 9:30 a.m. to 1:00 p.m. on March 11. For information contact: Marcia Vitiello, Coordinator for Continuing Education, (215) 243-2774.

Advances in Emergency Medicine

The Florida Chapters of the American College of Emergency Physicians and the Emergency Department Nurses Association will present the 6th Annual Postgraduate Seminar in Emergency Medicine, A LOOK FORWARD: RECENT ADVANCES IN EMERGENCY MEDICINE, March 16-19, Omni International Hotel, Miami, Florida. For information contact: Registrar, Sixth PGS, 600 Courtland Street, Suite 420, Orlando, Florida 32804. Telephone (305) 628-4800.

Birth Defects and Pediatric Mishaps Seminar

The Children's Hospital of Philadelphia will sponsor a seminar on BIRTH DEFECTS AND PEDIATRIC MISHAPS, March 17-18. The program will include case presentations, didactic lectures and panel discussions. Credit for Category I of the AMA Physician's Recognition Award has been applied for. For information contact: Patrick S. Pasquariello, Jr., M.D., The Children's Hospital of Philadelphia, One Civic Center, 34th Street and Civic Center Boulevard, Philadelphia, PA 19104.

1978 Graduate Medical Assembly

The New Orleans Graduate Medical Assembly will present THE HIGH RISK PATIENT, a trauma symposium and clinicopathological conference, March 31-April 4, at the Fairmont Hotel, New Orleans, Louisiana. The program is acceptable for Category I credit

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towards the Physician's Recognition Award. Application for accreditation will also be made to the American Academy of Family Physicians and to the American College of Emergency Physicians. For information contact: Ms. Lois Neary, Executive Director, The New Orleans Graduate Medical Assembly, 1430 Tulane Avenue, New Orleans, LA 70112.

**American College
of Allergists
Congress**

The 34th ANNUAL CONGRESS of the American College of Allergists will be held April 1-6, at the Las Vegas Hilton Hotel, Las Vegas, Nevada. A comprehensive review of clinical immunologic and allergic diseases relevant to the needs of the physician in practice will be presented. The program will fulfill 30 hours of AMA Category I credit. For information contact: Francis P. White, Executive Secretary and Treasurer, American College of Allergists, 2141 14th Street, Boulder, CO 80302. Telephone: (303) 447-8111.

CLASSIFIED AD SECTION

Advertisements under the Classified Ad Section are charged at the rate of 30 words or less, set solid. One insertion \$4.00. Call the Journal office, 658-7596 for further information or placement. All advertisements are payable in advance. The Editorial Board reserves the right to edit copy. Closing date for new copy is the first of the month for inclusion in the current issue.

Classified advertisements of a professional nature are free to members.

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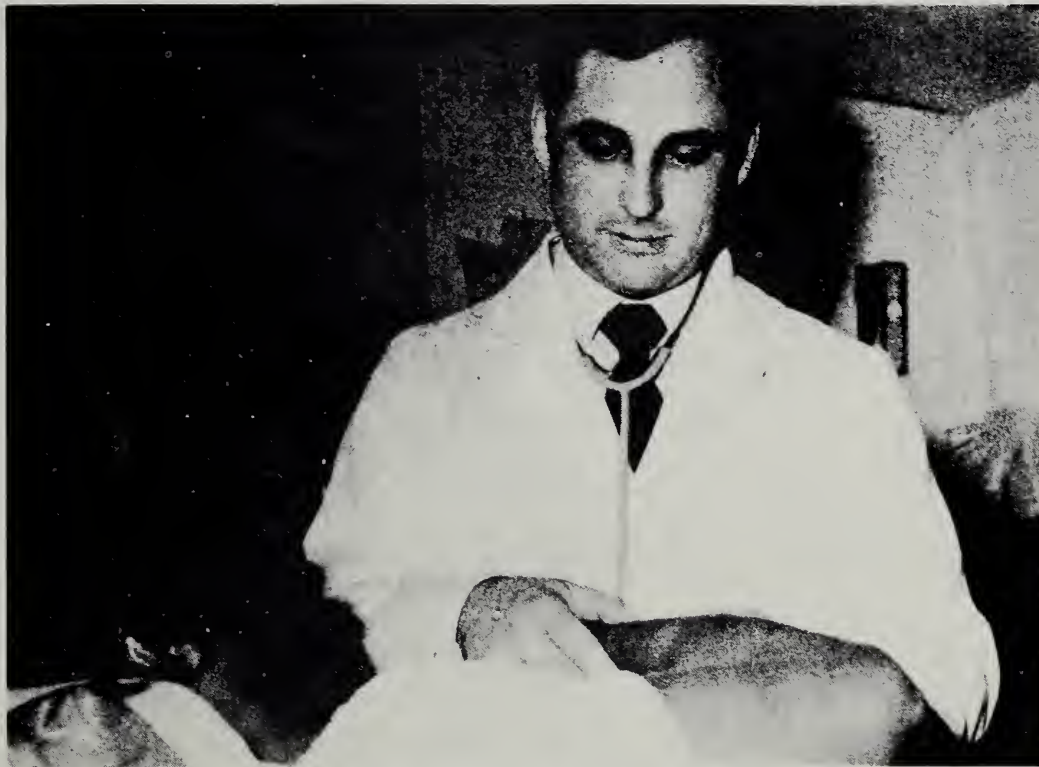
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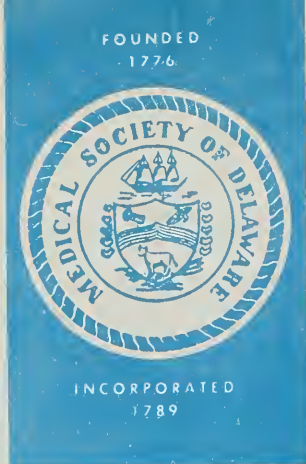
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Delaware

Medical Journal

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VOLUME 50

FEBRUARY, 1978

NUMBER 2

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cancer communiqué

FROM THE DELAWARE CANCER NETWORK*

THE ROLE OF BELIEF SYSTEMS IN CANCER THERAPY

THE REV. CARL R. SACHTLEBEN

Progress in the treatment of cancer has been difficult, but we are realizing some advances. We now have available new surgical techniques that allow for far more delicate and precise procedures. Chemotherapy enjoys a greater repertoire of treatment choices. In radiation therapy we have more sophisticated equipment and are able to reduce negative side effects. Although it is yet in its infancy, we stand before new frontiers in immunotherapy. Changes are happening in the use of combination treatments. More people attending the needs of cancer patients are involved in multidisciplinary discussions and teamwork activities. Hope resides in the area of preventive health where the focus changes from individualistic and disease-oriented care to community education and whole person care.

Psychological therapy as an adjuvant means of treating cancer patients is relatively new. It is not brand new because it has been happening throughout in the helping relationships offered by professional people working with cancer patients. However, heretofore not much of the psychological theory or practice has been systematically arranged and developed specifically for cancer care.

What we hear from people in psychological re-

search and study is that they are locating some pertinent factors that play a role in the course of the disease. One important factor is the role of one's *belief system*. When confronted by serious illness, such as cancer, people establish some sort of belief system that will give order to the experience. This process is an effort to gain a sense of control over the anxiety aroused by a threat of unknown origin and to attempt to find meaning and to maintain mastery. People related to cancer patients also develop attitudes and belief systems. For instance, cancer in our society is commonly perceived as an always-fatal and particularly loathsome disease; it is disfiguring, destructive, and frightening. These beliefs within the individual patient and within society have their effect on the course of the illness.

As people working therapeutically with cancer patients, we have a responsibility to foster a healthy and useful emotional environment for that care. In the first place, we can help the patient talk through *his beliefs* about his disease, his treatment, and his part in the course of the disease. When a patient expresses negative and hopeless feelings, we can introduce him to alternative beliefs. We can encourage him to "use himself," to become more confident that he can work for himself. "My body has an ability to repair itself" is a much more curative belief than

Mr. Sachtleben is Coordinator of Pastoral Services for the Delaware Cancer Network.

*An NCI-supported agency located at 1200 Jefferson Street, Wilmington, Delaware 19801. Tel. (302) 428-2113.

"My body is (I am) the victim of this evil (disease and/or treatment)." We can urge patients to image positive outcomes and the positive effect of the treatment on the destruction of malignant cells. Our first encounter with the patient and family following diagnosis is very important. For it is then, when the patient feels most vulnerable and expects the worst, that the imagery process is very active.

Secondly, we can invite the family of the patient to express *their beliefs* about the disease and its outcome. The patient spends far more time interacting with the beliefs and attitudes of family members than he does with us. Family members can do much to give support and encouragement to the patient, but only when they are aware of the significance and role of their attitudes and beliefs.

And, most important, we can be aware of *our own beliefs* about the treatment we are administering and about the patient's own ability to influence the course and outcome of his disease. Our expectations about ourselves and about the patient are a powerful influence on the patient, so it makes a difference what those expectations are. For instance, our expecting to *do something* to a patient is different from our expecting to *guide* or to *participate with* the patient in his treatment, and that difference has an effect on the course and outcome of the disease.

In 1959, Dr. Eugene P. Pendergrass, in his Presidential Address to the American Cancer Society, concluded, "As we go forward . . . searching for new means for controlling growth both within the cell and through systemic influences, it is my sincere hope that we can widen the quest to include the distinct possibility that within one's mind is a power capable of exerting forces which can either enhance or inhibit the progress of this disease."

What is most important is that the patient is not the object of our care, but rather a person who is enlisting us as a partner in the healing process. Care is predicated on the condition of reciprocal trust. What we believe and what we expect is a critical and active ingredient in the process of treatment.

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DESCRIPTION Each yellow, scored tablet contains 4.50 mg. oxycodone HCl (WARNING: May be habit forming), 0.38 mg. oxycodone terephthalate (WARNING: May be habit forming), 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.

INDICATIONS For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS Hypersensitivity to oxycodone, aspirin, phenacetin or caffeine.

WARNINGS **Drug Dependence** Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of PERCODAN®, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, PERCODAN® is subject to the Federal Controlled Substances Act.

Usage in ambulatory patients Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using PERCODAN® should be cautioned accordingly.

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Usage in children PERCODAN® should not be administered to children.

Salicylates should be used with caution in the presence of peptic ulcer or coagulation abnormalities.

PRECAUTIONS **Head injury and increased intracranial pressure** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions The administration of PERCODAN® or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special risk patients PERCODAN® should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

Phenacetin has been reported to damage the kidneys when taken in excessive amounts for a long time.

ADVERSE REACTIONS The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include euphoria, dysphoria, constipation and pruritus.

DOSAGE AND ADMINISTRATION Dosage should be adjusted according to the severity of the pain and the response of the patient. The usual adult dose is one tablet every 6 hours as needed for pain.

DRUG INTERACTIONS The CNS depressant effects of PERCODAN® may be additive with that of other CNS depressants. See WARNINGS.

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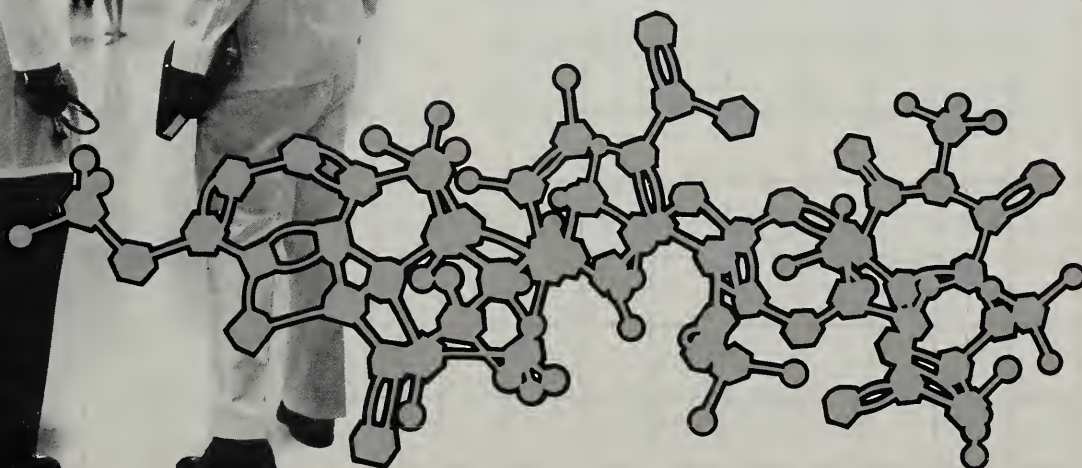
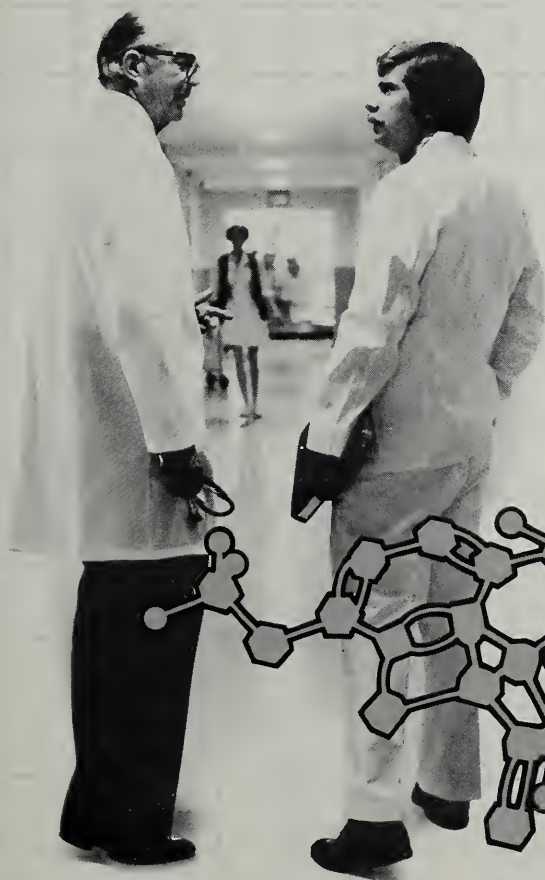
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Manuscripts

All manuscripts submitted shall be original, never before published and contributed solely to the Delaware Medical Journal. They should be addressed to the Editor, 1925 Lovering Avenue, Wilmington, Delaware 19806, who reserves the right to reduce, revise, or reject any material submitted for publication.

Copy should be typewritten, double-spaced on 8½" x 11" white bond paper. In addition to the original, two copies are desirable.

The professional affiliations of each author should be supplied. Uncommon abbreviations should be written out in parentheses the first time they are used. Names, initials, or other information that could identify a patient should be eliminated from the copy. If photographs of patients are used, either the subjects should not be identifiable, or their pictures must be accompanied by written permission to use the figure.

Review and Action

Manuscripts are customarily examined by the editorial staff and sent out to two reviewers. Authors are usually notified within two to six weeks as to the acceptability of a manuscript, but sometimes longer delays are unavoidable.

Contributors will be notified as soon as a manuscript is received. Unaccepted manuscripts will be returned.

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1. Fine RN, Brennan LP, Edelbrock HH, et al: Use of pediatric cadaver kidneys for homotransplantation in children. JAMA 210:477-484, 1969.

Example of a book:

- (2) Morgan WL, Engel GL: The Clinical Approach to the Patient, p 85. Philadelphia, WB Saunders Co, 1969.

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President's Page

UNITED WE STAND

Quite often young physicians or men and women interested in a career in medicine ask about the American Medical Association and the Medical Society of Delaware and the reasons for membership.

The American Medical Association and the Medical Society of Delaware provide consultation and representation where needed on behalf of members, individually or collectively, with respect to grievances, disputes with third parties professional problems, governmental regulations, or terms or conditions of salaried employment by hospitals or privileges in the case of attending physicians who are not hospital employees. Membership gives one eligibility for the professional and personal insurance programs.

The benefits vary with the degree of involvement of each participant, but the one underlying purpose is the need for a unified voice and action by the medical profession at this critical juncture in our national life.

Federal and state intervention into the practice of medicine, attempted control through legislative fiat, harassment and governmental regulation have never been more widespread—and they demand constant attention. In reality some of them are thinly veiled attempts to deprofessionalize

physicians into a trade or public utility, and they require an organized response.

For the sake of our patients, as well as our own continuing self-respect, there is a need for a unified effort by the medical profession to maintain the highest possible standards of medical practice, education, and research.

The Medical Society of Delaware and the American Medical Association are unifying forces whose role is to blend the viewpoints of all physicians into concerted and effective action. The strength of organized medicine derives entirely from the participation and support of individual physicians.

Membership in the Medical Society of Delaware and the American Medical Association—the federation of State Medical Societies—can be a formidable force in shaping the destiny of American medicine in such a way that monumental advancements of the recent past will continue into the foreseeable future to the ultimate benefit of all mankind. United we stand!

John J. Egan, M.D.

Deaths

BRUCE BARNES, M.D.

On Wednesday, August 31, 1977, Bruce Barnes, M.D., of Pine Street in Seaford, Delaware, died.

Aged 81, he had been hospitalized for a long illness. He was born October 17, 1895 in Newfoundland, New Jersey, the youngest of three sons, and his father was a school teacher. He attended schools in upper New Jersey and entered New York University for his pre-medical education.

In 1921, he graduated from the University of Maryland Medical School. He married Ivy Mae Peckhart, of Paterson, New Jersey, August 11, 1921.

During the next few years, he served as resident physician in several sanatoria, specializing in the care of tuberculosis patients.

While living in Dunkirk, New York, he served for a short time as a physician who limited his practice to industrial medicine, but, missing the human contact, he decided to accept the offer of William F. Haines, M.D., in Seaford, Delaware to become his associate in 1926.

From that date until early in 1972, he was a family practitioner; in February, 1972, because of a cerebrovascular accident, he was forced to retire from active practice.

Active in the Sussex County Medical Society and the Medical Society of Delaware, as well as the AMA, he was also an active member of the Delaware State Board of Health for approximately 12 years and in 1940 served as President of the Medical Society of Delaware. He was also a member of the Seaford Board of Health and during World War II served as a member of the Selective Service Board.

He had a close working relationship with his daughter, Doris R. Barnes of Seaford, who became the recipient of much of his experience and philosophy.

Bruce Barnes felt that it was the duty of every physician to be sincerely concerned with the care of his patient as a whole person and that the patient should be treated with meticulous competence, regardless of financial remuneration, creed, or color. Those who knew him closely realized that he lived such an ideal for almost 50 years of active practice.

His wife, Ivy Peckhart Barnes, died in 1952 and his daughter, Dr. Doris R. Barnes of Seaford, is his only survivor.

Graveside services were held at the Odd Fellows Cemetery in Seaford on Friday, September 2, 1977.

CHARLES M. BANCROFT, M.D.

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JAMES B. HOMAN, M.D.

James B. Homan, M.D. 68, of Milford, Delaware died on November 6, 1977, at Milford Memorial Hospital after a long illness.

Jim, born and raised in the Wilmington area and for many years a practicing dermatologist in Dover, was an individual of inherent brilliance, industry, and talent, which allowed him to be many things to many people.

Jim graduated from Hahnemann Medical College in 1937. After completing his internship at the Homeopathic Hospital (now the Memorial Division of the Wilmington Medical Center), he completed a two-year residency in psychiatry in Middletown, New York, after which he served five years of active duty in the US Army Medical Corps.

He received his dermatologic training at the University of Pennsylvania. A diplomate of the American Board of Dermatology, he was a member in good standing of many component medical societies, having served as immediate past president of the Delaware Academy of Dermatology.

He was an ardent sportsman, excelling in fishing and hunting. A personal aspect to Jim's life was his devotion to his family: his wife, Betty; a daughter, Christine Foulk of Middletown; two sons, Michael of Westfield, New Jersey, and Jeffrey of Lafayette, Colorado; and seven grandchildren.

All of us who knew him were fortunate indeed, as he set standards of excellence that will challenge us always.

Contributions are being accepted for the Memorial Fund of Christ Episcopal Church of Milford.

ELMER R. GROSS, M.D.
CHARLES M. BANCROFT, M.D.

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KARNIK GURDIKIAN, M.D.

Karnik Gurdikian, M.D., aged 53, died suddenly November 7, 1977.

A staff physician for the Mental Hygiene Clinic in Wilmington, Delaware, he was also President of the Delaware Psychiatric Society, and had served as a psychiatric consultant to the Department of Correction. He had also been Clinical Director at the Delaware State Hospital.

Dr. Gurdikian was born in Istanbul, Turkey. After studying and serving as a physician in parts of Europe, he came to the United States approximately 23 years ago. He was a student at the Eastern Pennsylvania Psychiatric Institute. He had been in private practice in Wilmington for approximately 20 years as a neuro-psychiatrist.

He is survived by his wife, Eleanor; two sons, Robert and Ronald; and a daughter, Greta, all at home.

Contributions in his memory are being accepted by the Delaware Heart Association, Independence Mall, or by the Mental Health Association of Delaware, 1813 N. Franklin Street, Wilmington.

CHARLES M. BANCROFT, M.D.

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We're working hard to control the cost of health care...so help us.



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MEDICINE, MORTALITY, AND LIFE INSURANCE

JOHN O. ALDEN, M.D.

Life insurance medicine is a specialized field with which most physicians' contact is limited primarily to supplying medical information on their patients who are applying for insurance coverage. Given these circumstances, it is inevitable that questions and indeed certain misconceptions may develop concerning the medical selection process. This article is intended to provide insight into how those of us in this field apply medical knowledge and utilize medical information in evaluating the mortality risk of life insurance applicants. Although the discussion is limited to life insurance, a somewhat similar process is utilized in evaluating the morbidity risk of individual health insurance applicants.

Differences in Approach

There are several basic differences between the clinical and the insurance medical approaches which deserve attention. To begin with, the clinician is primarily concerned with current

problems, whereas the insurance physician looks chiefly to the future or long-term prognosis. Secondly, the clinician usually can observe the patient over a period of time and modify treatment or even the diagnosis as new factors emerge. By contrast, the insurance physician has only one opportunity to assess available information and make a decision. This decision is generally irrevocable because a life insurance policy cannot be cancelled, rated up, or modified once it is issued. An important exception is the policy initially issued at an increased premium for medical reasons. This may qualify for a premium reduction at a later date if the mortality risk of the insured improves.

The clinician thinks chiefly in terms of the individual patient, whereas the insurance physician must compare the individual's medical findings with hundreds of persons with similar findings in order to determine the average expected mortality of the group. This fundamental insurance premise is based on the fact that no one can predict the mortality of an individual with any degree of accuracy. In addition, the

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This paper was adapted from a presentation to the Department of Medicine, Wilmington Medical Center, Wilmington, Delaware.

insurance physician is interested in seemingly minor findings, such as mild blood pressure elevation, slight proteinuria, or chest pain of questionable etiology, which may not represent any immediate threat to health but are known to have long-term mortality implications.

We in insurance medicine have at times been accused of being pessimists because we think in terms of mortality instead of survival. The example illustrated in Figure 1 shows why this is necessary. In the survival statistics alone, there is very little difference between the results in Group A and Group B and only a modest drop in Group C. From the mortality viewpoint, however, Group B has twice as many deaths and Group C has five times as many deaths as the standard Group A. If one assumes that each person in the illustration has a \$25,000 life insurance policy, \$300,000 in death claims would be paid in Group A, \$600,000 in Group B, and \$1,500,000 in Group C. Needless to say, these differing results are of great importance to an insurance company.

Many clinical articles reporting survival statistics on a particular group of patients present a problem in interpretation for insurance physicians as they are not age- and sex-adjusted for the mortality expected in a similar group of normal people. For example, a five-year survival of 88% would be about normal for men aged 72, but would represent twice as many deaths (200% mortality) as expected at age 62, and ten times as many deaths as expected (1,000% mortality) at age 42. In other words, the survival or mortality results in a given study must be related to the standard or average mortality expected in

a group of similar age and sex distribution to be truly meaningful.

Mortality Classifications

In evaluating life insurance applicants, a number of mortality classifications are used. The standard mortality group is by far the largest and consists of persons whose expected mortality is close to the insurance company's standard mortality table. That is, the ratio of actual deaths to expected deaths is approximately 100%. Most companies include in their standard group persons with an expected mortality of up to 125%, or even higher. Thus, usually more than 85% of life insurance applicants qualify for standard insurance. In addition, there are several special class mortality classifications which are used where extra mortality is expected. Aetna has 12 such classifications ranging from 150% to 1,000% mortality. In the 150% classification there would be 1.5 times as many deaths expected as in the standard group, and in the 1,000% classification there would be ten times as many deaths expected as in the standard group. A higher premium is charged in each of these special class groups to cover the extra mortality. The percentage increase in premium is usually less than the percentage increase in expected mortality, however, because other factors such as expenses and interest earned on policy reserves enter into the premium calculations. Finally, a small percentage of applicants—approximately 2.5% at the Aetna—is declined because their mortality risk is either above the company's highest mortality classification or is too uncertain to properly classify. Some of these can be considered for coverage at a later date, for example, after re-

FIGURE 1

EXAMPLE: Three groups of 1,000 men aged 42, each insured for \$25,000.
The standard mortality expected in five years is 12 deaths.

	Experience	5-Year Mortality	5-Year Survival	Death Claims Paid
Group A	Actual Deaths = Expected Deaths (Standard Group)	12 (100%)	98.8%	12 Deaths = \$ 300,000
Group B	Actual Deaths = Twice Expected Deaths	24 (200%)	97.6%	24 Deaths = \$ 600,000
Group C	Actual Deaths = 5 Times Expected Deaths	60 (500%)	94 %	60 Deaths = \$1,500,000

covery from a current illness or after a diagnostic work-up is completed.

There are two basic types of applications used for individual life insurance. One is the non-medical application on which the applicant answers the medical questions, and no examination is involved. This is used mostly for applicants under age 40 applying for smaller amount policies. The other type is the medical application which automatically includes an examination by a physician. Examinations are generally required when larger amounts of insurance are involved or the applicants are over age 40. Of course, younger applicants with a significant medical history may also be examined when a current evaluation is needed.

In recent years the life insurance industry also has utilized the paramedical examination, which is performed by a nurse or other specially trained technician. This consists of the medical history plus height, weight, pulse, and blood pressure measurements and serves as an intermediary screening device between the non-medical application and a full medical examination performed by a physician. A urinalysis usually is obtained with both the medical and the paramedical examinations, particularly where the applicant's medical history or findings so indicate. Additional special studies may be performed, including a resting or exercise electrocardiogram, chest x-ray, CBC, and blood chemistry determinations. Although a stress ECG, such as the treadmill test, is used on occasion, most companies rely on the augmented Master's test because it is readily available in small as well as large communities and has proven to be a reasonably reliable indicator of mortality prognosis for up to ten years in the future.

The attending physician's report is a very important source of medical underwriting information. This is needed when the applicant cannot supply the needed details of his medical history or the medical impairment in question cannot be properly evaluated by an insurance physical examination alone. Without this report it is often impossible to make an intelligent underwriting decision. The insurance industry has attempted to alleviate the paperwork burden for physicians by adopting a standardized attending

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physician's statement form and reducing the number of requests for information whenever possible. Some companies have installed telephone recording systems in their medical departments so that physicians may call collect at any time of the day or night and dictate their reports instead of filling out the form. At the Aetna such reports are transcribed by our medical secretaries, and a copy is always sent to the physician together with a check covering his fee. Many physicians find this method to be a great convenience as well as a means of obtaining a brief summary for themselves of their patients' records.

The Medical Information Bureau

A further source of medical underwriting information is the Medical Information Bureau (MIB), a nonprofit trade association servicing approximately 700 life insurance companies in the United States and Canada. To qualify for membership, a company must have a locally licensed physician serving as medical director. The purpose of the MIB is to flag information of

underwriting significance that an applicant may forget, withhold, or simply not know. All MIB information is in coded form, and no medical records of any kind are sent to or maintained in the Bureau's computerized file. Each applicant for life or health insurance receives a printed notice describing his MIB entry at the time of application and authorizes its use in writing. Instructions are included in the notice on how to contact the MIB to determine if there are any codes entered on the individual in question. The meaning of a medical code, however, is revealed only to the attending physician by the medical director of the company that initially reported the code. This process permits the attending physician to explain technical medical data to the individual and also avoids direct disclosure to the individual of sensitive medical information by the insurance company. The Medical Information Bureau operates under very strict rules. Only member life insurance companies have access to its records, and there is no exchange or tie-in with any outside data bank or file. Furthermore, a company cannot rate, modify, or decline a policy on the basis of MIB information and must verify the information through its own sources. MIB staff periodically audit company records to assure compliance with these rules. A more complete description of the MIB and its operations may be found in an article by Paul S. Entmacher, M.D. in the JAMA 233:1370-1372, 1975.

Determination of Specific Mortality Classifications

We now come to the question of how the medical evaluation of an applicant is translated into a specific mortality classification. Most if not all companies use what is called the numerical rating system. Under this system it is assumed that the average standard risk has a mortality value of 100%. Various specific risk factors are expressed numerically depending upon their mortality implications. Unfavorable risk factors (debts) are added to the basic risk of 100% and favorable factors (credits) are subtracted. The various debts and credits are then added together to determine the total mortality risk. Several examples of this process are illustrated in Figure 2. Advantages of this system include a greater consistency from case to case

FIGURE 2

EXAMPLE 1: A 45-year-old male with no significant medical history and who has not seen a physician within five years. Physical examination reveals no abnormalities except for a blood pressure of 160/94. On recheck, the blood pressure is 165/90. Urinalysis, resting electrocardiogram and chest x-rays are normal.

Mortality Assessment

Basic Mortality	100
Blood Pressure Debit	+100
Credit for Normal Build	- 10
Credit for Normal Urinalysis	- 10
Credit for Normal ECG	- 15
Credit for Normal X-ray	- 10
Total Mortality Assessment	155%

EXAMPLE 2: A 36-year-old male with a history of diabetes for which he takes insulin daily. Physical examination is essentially normal and urinalysis is normal except for the presence of 300 mg/100 ml of glucose. The attending physician's statement indicates that this applicant has been a known diabetic for 12 years and that his diabetes has been reasonably well controlled by diet and 30 units of insulin daily. There have been no hypertension, albuminuria or other complications of diabetes and no other significant disease.

Mortality Assessment

Basic Mortality	100
Diabetes of 12 Years' Duration (debit)	+150
Total Mortality Assessment	250%

EXAMPLE 3: A 55-year-old female who indicates to the examiner that she is a mild diabetic. Physical examination and urinalysis are normal. The attending physician's statement indicates that this applicant was found to be diabetic two years ago and has been controlled by diet alone. There have been no hypertension, albuminuria or other significant diseases.

Mortality Assessment

Basic Mortality	100
Diabetes of Two Years' Duration (debit)	+ 50
Credit for Control by Diet Alone	- 25
Total Mortality Assessment	125%

and greater assurance that all factors are considered. Furthermore, it has sufficient flexibility to allow for individual judgment on complex cases and unusual circumstances.

Most companies have a medical underwriting manual which provides a guide of suggested debits or debit ranges for various medical impairments and findings, allowing for such factors as severity or degree, number of acute episodes, chronicity, response to treatment, time elapsed since occurrence, and associated conditions or complications. The manual is particularly useful to lay underwriters, who usually review applications first and act on the more routine cases themselves. Generally speaking, the insurance physician sees only applications involving medical problems or requiring interpretation of electrocardiograms, x-rays, etc. At Aetna the medical underwriting manual is periodically revised taking into consideration our own mortality experience with specific impairments, outside mortality statistics, and clinical medical experience and advances. At times we may liberalize on an impairment in anticipation of improved mortality from medical advances. For example, we assumed improved mortality on persons whose blood pressure was controlled with antihypertensive drugs some years before mortality statistics to support this assumption were available. Based on our own experience, this assumption has now proven to be true.

To illustrate how the numerical rating system operates in practice, three sample cases are illustrated in Figure 2. The numerical debits and credits used in each of these examples do not necessarily represent the actual figures that would be used by any one insurance company. In all three examples it is assumed that a physical examination was obtained as part of the insurance application process.

The belief persists in some quarters that individual life insurance cannot be obtained unless one is in nearly perfect health. Although some people's idea of "perfect health" cannot be supported by insurance mortality experience, individual policies are regularly issued at an extra premium to applicants with histories of significant medical impairments. A prime example is the individual with a history of myocardial infarction.

Many companies offer insurance coverage as early as six to twelve months after the episode provided the individual is back to work or usual activities, the electrocardiogram is stable, and there has been no decompensation, significant arrhythmia, or angina subsequent to the acute illness. A few companies are now insuring selected individuals who have had coronary bypass surgery a year or more in the past. Other insurable impairments include most internal cancers three or more years after successful removal with no recurrence, ulcerative colitis and regional enteritis in remission, certain cerebral vascular disorders and psychoses two to three years after the acute episode if currently adjusted. Obviously, major impairments such as these require careful evaluation, and reports from the attending physicians are essential.

Sources of Mortality Statistics

Mortality statistics are obtained from a variety of sources. Each company looks first to its own experience, both overall and by specific categories. Periodically, the Society of Actuaries and the Association of Life Insurance Medical Directors of America conduct mortality studies in which the experience of a number of companies is pooled to gain broader exposure and thus more reliable statistics. Currently two such studies are underway. One involves build (overweight) and blood pressure, both separately and in combination with each other and with and without a history of blood pressure treatment. The second is a mortality study of atrial fibrillation. Other sources include the Veterans Administration, the National Institutes of Health, state tumor registries, and public health authorities, as well as private clinical investigators. Readers interested in obtaining mortality and survival data on a great variety of medical impairments and findings are referred to the new volume, *Medical Risks: Patterns of Mortality and Survival* by Singer and Levinson.* This is the first major work in which many published clinical studies have been analyzed and related to appropriate mortality/survival tables. It is of value to the clinician and the insurance physician alike.

*Singer RB, Levinson L: *Medical Risks: Patterns of Mortality and Survival*. Lexington, Massachusetts, Lexington Books, D. C. Heath & Co, 1976.

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REALITY ORIENTATION

C. L. HUDIBURG, M.D.

The constant increase in the number of senior citizens is giving us an ever-increasing number of mentally disoriented aging patients. A Biological and Behavioral Study of Human Aging^{*} classified these patients' characteristics, symptoms, and signs as follows:

- Difficulty in maintaining attention
- Frequent flight of ideas
- Impairment of memory, especially for recent events
- Impairment of orientation
- Intellectual "decline"
- Reduced tempo of stream of thought
- Impoverishment of ideas
- Increasingly impaired concentration
- Progressive withdrawal and self-isolation
- Reduced responsiveness
- Increasing memory loss
- Liability to "distintegration" during stress
- Impaired judgment

No more than 35 years ago the teaching was that arteriosclerosis was a primary factor in causing senility. In 1948 Alpers, Forster, and Herbut taught that arteriosclerosis had selective organ effects, that cerebral arteriosclerosis might occur in the absence of changes in other organs, and that in some cases arteriosclerosis could occur in localized areas of the brain only; however, both prevention and treatment seemed ineffectual, and hopes of a cure were discouraging. Those patients who had no specific pathology lived on and on in a most undignified and humiliating manner. It seemed that there should

have been a better way to age. Today there are training programs that seem to help in both prevention and treatment.

Is senility an appropriate term for the befuddlements of old age? Alabama specialists say, "No, it can be found at many ages, and sometimes it is a reaction to simple stress." Administrators of convalescent and nursing homes in many states recently met with these experts from the Alabama Veterans Administration Hospital to study their Reality Orientation Training Program.

Dorothy Scarbrough, Director of the program, believes that the word senility is often used inappropriately. The Alabama training program teaches techniques which diminish these peoples' confusion. Such disorientation can occur following severe accidents, injuries, postoperatively, and sometimes after severe emotional trauma such as the loss of a spouse. It also may be aggravated by the loss of a home and life's sentimental belongings.

Some people are thought to be senile when actually their problems are much simpler. Mrs. Scarbrough advises that new symptoms can be created by giving too much care. The elderly should not be treated like children as if they were "different." Such reactions to an aging person often increases their confusion.

The Alabama training program stresses that the more activity and sense of responsibility older persons have, the more they will retain mental alertness. All personnel connected with care of oldsters should seek to slow deleterious aging processes by encouraging patients to participate

^{*}Dr. Hudiburg, an obstetrician-gynecologist, is now retired and lives in Wilmington.

^{*}Birren JE, Butler RN, Greenhouse SW et al: Human Aging, pp 218-234. Washington, D.C., US Dept HEW.

in on-going life activities and to sustain their hobbies. Without this, treatment often seems so futile that it is discouraging to attendants, who feel they are wasting their efforts.

Once a month the Alabama Reality Orientation Training Program conducts five consecutive days of intensive training. Classes are limited to 15 chosen applicants. The program consists of lectures, discussions, audiovisual aids, and observations of team and class groups. Reference material is supplied to each trainee. There is no charge for the course.

The Alabama patient care program was established in the early 1960's for the rehabilitation treatment of confused individuals. The training sessions are for personnel who in any way care for confused and disoriented people. The training is a direct help to attendants as well as being instructive for supervisors and others who may conduct classes in their own hospitals or infirmaries as continuing education courses.

Reality Orientation is not something new. There are over 200 places in the US where classes are conducted. It is probably true that only three people from Delaware institutions have gone to Alabama for training. They, like most trainees, are very enthusiastic about it and feel that Reality Orientation should be a must in every health facility.

There is not only the need for trained nurses to promote and teach organized classes but also a financial need for teaching aids such as films

that are for rent or for sale, training kits and packets, administrator's guide book, student's work books, cassette recordings, etc.

This seems a bright ray of hope. Before long, senility may no longer be accepted by a large segment of the population as a nonpreventable and incurable deterioration.

There are senile people who get good custodial care living at home with relatives. Many times, however, they are living with an untrained dominant personality who unknowingly overwhelms them with do's and don't's. An idea of being unwanted and unneeded hastens the onset of senility. Consider the hundreds of people who are suddenly removed from their lifelong surroundings and put into one or two rooms with but few of their heirlooms and with nothing to do but ponder their fate. Even though they may say they love their "new home," their feelings of abandonment can be readily sensed.

What happens to these people? If you were one of them, would you gradually become accustomed to spending more and more hours alone? Would you perhaps be satisfied with the quietude? Would your interest in things lessen?

After many weeks you would feel slightly inadequate to meet people and try to converse. You would enjoy the occasional visitor but become less sociable. Without realizing it you would soon have forgotten how to be interested in life and in people and in how to make people



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interested in you. Gradually you would sense that attempts to express yourself are usually interrupted. There would be less need to think and remember.

Certain environments seem more conducive to pre-senile attitudes. Here is where early intervention is needed. Without planned activities other than daily chores, and without mental exercise, forced concentration, and attempts at remembering, patients soon become too introspective and speak only when spoken to. By now the senility is sometimes aggravated by tranquilizers which make the days slip by and make it easier to accept custodial care. Soon patients do not know what day it is, or even what year; often the desire to eat goes and weight loss occurs. All such patients are likely to lose their glasses and their false teeth. There may also be times when attempts to help them are misunderstood, and they violently resist or even refuse proper care. Then it becomes necessary to shackle them to the bed or a chair.

Surely many of Delaware's disoriented patients are missing the compassionate care that is necessary for improvement and prevention. Good physical nursing care can prevent lost clothing or false teeth, accidental falls, and bed sores. It is also crucially important that all personnel should be trained to realize that a sense of dignity and self-worth is needed for proper care.

BIBLIOGRAPHY

1. Barnes EK, Sack A, Shore H: Guidelines to treatment. *Geront* 13:513, 1973.
2. Barnes JA: Effects of R.O. in geriatric patients. *Geront* 14: 138, 1974.
3. Citron RS, Dixon DN: R.O. therapy in institution for aged. *Geront* 17:39, 1977.
4. Folsom JC, Folsom G: The real world. *Mental Hygiene* 58: 29, 1974.
5. Folsom JC: R.O. for the elderly mental patient. *J Geriat Psy* 1:291-307, 1968.
6. Gubrium J, Ksander M: Multiple realities and R.O. *Geront* 15:142, 1975.
7. Hackley JA: R.O. brings patients back. *Modern Nursing Home* 31:48-49, 1973.
8. Harris C, Ivory P: Outcome evaluation of R.O. therapy in state hospital. *Geront* 16:496-503, 1976.
9. Hefferin C, Hunter RE: Turn an idea into a program. *Nursing* 5:89-94, 1977.
10. Alfgrén J: Reality orientation—starting your own program. *Nursing* 4:88C-88L, 1977.
11. Jahraus AM: Who is confused. *Nursing Homes* 23:6-9, 1974.
12. Scargrough DR: R.O. is no part time job. *Geriatric Care* 3, 1976.
13. Shannon M: Return to reality. *Atl J Const/Mag* 1, 1972.
14. Smith BJ, Barker HR: Influence of R.O. training program, —attitudes of trainees toward elderly. *Geront* 12:262-264, 1972.
15. Pamphlet—R.O.T.P.: Tuscaloosa Veterans Administration Hospital, Tuscaloosa, Alabama 35401. R.O.T.P. Catalog Manual Arts Therapy Clinic, 1977.
16. Sarton M: *As We Are Now*. New York, Norton Co, Inc, 1973.
17. Phillips DF: Reality orientation. *J Am Hosp Ass'n* 47, 1973.
18. Birren JE, Butler RN, Greenhouse SW et al: *Human Aging*, pp 218-234, Washington, US Dept HEW.
19. Sarton M: *As We Are Now*. New York Norton Co, Inc, 1973.

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Letters to the Editor

To the Editor:

A search for a chart and an autopsy protocol of a patient who had died in 1947 brought me to the General Division of the Wilmington Medical Center. I learned that charts are kept for 25 years, that older autopsy reports could, perhaps, be found in the store room. I followed a secretary to the basement. We could not find reports from 1947 or 1946, only those from 1945. Later, we came across a ledger with entries for all these years, just names and dates.

I looked through the 54 manila folders with autopsy reports from 1945. Five patients had died of diseases which, fortunately, have become rare or extinct in the US: cerebrovascular syphilis, tuberculous meningitis, multiple tubercles in the brain, tetanus, and laryngeal diphtheria.

My visit to the hospital basement turned into a medical adventure, into a lesson on medical progress. This could be experienced by others. Today's residents in pathology, medicine, pediatrics are unfamiliar with diseases which we used to see rather often thirty years ago. Why not keep charts and autopsy protocols forever, maybe on microfilm?

Nostalgia can be loosely defined as longing for the good old days. There is no term to express the opposite sentiment. Happily, some of the good old days are gone forever. But this is not a valid excuse for discarding valuable teaching material.

O. J. POLLAK, M.D.

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To the Editor:*

It is too bad that Joe Smyth, who wrote the editorial DIAGNOSIS LOUSY, does not like the DIMER program. By his "smart aleck" approach, Mr. Smyth has vented opinions without the benefit of adequate background information. Before DIMER, approximately 20 students per year from Delaware entered medical schools. This number has nearly doubled with the advent

of DIMER. His figure of 40 students in out-of-state schools includes those in all four years, not just one class. Delaware students, for the first time, have a reasonable chance of getting into medical school. The competition is severe. In most states, medical schools are so heavily subsidized by their states that students from outside seldom gain admission. For example, University of Maryland School of Medicine admits three from out-of-state per year, West Virginia, two, and some New York State Universities, none. Delaware students have been sponging on taxpayers from other states, who have to subsidize their own schools. It is only fair for Delaware to provide students a chance for medical education. This is a likely method of attracting American-trained physicians to the state.

The fact is that, for a bargain (2.3 million dollars a year), Delaware has been able to have the equivalent of a medical school. There are very few states where medical education can be so inexpensively subsidized. A medical education costs about \$20,000 per year per person. The average \$4,000 to \$6,000 tuition only pays part of this. The average student needs a fiscal "angel" to pay full costs. Georgetown University in Washington, D.C., with no state subsidy, is now charging \$12,000 per year tuition. Most students from Delaware cannot tolerate this kind of financial barrier. It is truly impossible for the average family to underwrite a medical education.

Without doubt, the best medical care in the world is in the United States. If you don't believe this, just look at the number of students from around the world who are attracted here for study. American medical education's superiority is documented by a recent study in the *New England Journal of Medicine*. Students trained in America score significantly better on all specialty examinations than Americans trained abroad, (where a language barrier cannot be used as an excuse), or than students from abroad who only have their hospital training here.

Delaware's "bargain medical school" through DIMER also provides post-graduate educational activities throughout the State, such as monthly

*This letter was originally published in the *Delaware State News* of December 28, 1977.

conferences in each hospital. This stimulates improved care throughout the whole area for doctors already in practice. In addition, good physicians have been attracted to the state to help in the accredited medical school training at the Wilmington Medical Center for third and fourth year students from Jefferson. The Wilmington Medical Center is one of the prime rotations according to the Jefferson students. This does not happen by chance.

Since DIMER, Delaware has gained approximately 200 physicians. Although DIMER may not take the credit for all, certainly many were attracted by the teaching opportunity. The report by Joe Smyth that only two DIMER-trained physicians have returned to practice in Delaware is not a true picture of the total impact of the program because most are still in training, or are in the US Public Health Service, or the Armed Services. Actually of the eight DIMER graduates who have completed their training and entered practice, five are practicing in Delaware,

and the other three have been made up for many fold by doctors from other states who have gone into practice here. It takes approximately eight to ten years from entering medical school before the average doctor is ready to practice. DIMER has been in effect seven years. Students often do not practice in the state in which they were raised. Interestingly, many practice in their spouse's state. But the climate for practice, stimulated by the DIMER academic program, will continue to attract physicians. The acute shortage problems are better than ten years ago when there were, for example, only eight physicians in the Seaford area to cover 34,000 people. I work in all hospitals in Delaware and can see the improving quality of care in Kent and Sussex County hospitals. I hate to see anything done to interfere with the stimulus evident in the past few years.

I can't believe that Mr. Joe Smyth would rather put money into roads, prisons, and bureaucratic nonsense used to run the State of Dela-

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ware than in efforts to improve health care. The 2.3 million formerly invested in DIMER is a relatively small proportion of the 360 million dollar budget. The \$841,500 appropriated this year that Mr. Smyth would like to eliminate represents a commitment made to Jefferson Medical School and 80 Delawareans enrolled there. I don't believe we are in such a bad situation that we should default on obligations to our own citizens.

The health care of the indigent is not supported by the city or county governments, except for mental hospitals, and possibly in some ambulance transport activity. But those without transportation are being hit hardest by the current restrictions. The State does not pay *any* of the cost of indigent care in the hospitals. Its Public Health program is poorly supported.

It is not quite clear where 350 million dollars of the State money goes each year, except that a fair proportion goes for supporting bonds for school buildings that are no longer needed. A sixth of the budget for schools is for busing. The amount spent for recreation far exceeds that spent for health. The State apparently is willing to spend \$20,000 to research a worthless drug, Laetrile, but does not support a budget to pay for more than one salary for radiation protection for the entire State. Delaware is preparing to pay an out-of-state hospital \$1.2 million to provide medical care for prisoners. Think of it—\$1,200,000 for the prison health service but only \$841,500 for medical education for the most talented and highly motivated young people in the State. Which is the better bargain for our people?

When it comes to priorities, health care has long had a back seat. The one bright light has been the DIMER program, and even that was a "bargain basement" bargain. To have the Governor and his cohorts, including Joe Smyth, so little informed as to not realize the gem that they have only confirms the fact that we in the health field have to tell our story better. If Mr. Smyth were doing the constructive things he should be doing, he would first acquaint himself with some of the facts and then help tell that story.

ROBERT W. FRELICK, M.D.

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Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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THE "HEALTH-ORIENTED" FRINGE BENEFITS OF A PROFESSIONAL CORPORATION

LEIF C. BECK, LL.B., C.P.B.C.
VASILIOS J. KALOGREDIS, J.D.

While the primary (and often sole) reason for practicing as a professional corporation will typically be retirement plan opportunities, the variety of other fringe benefits seems too often either confused or overlooked. Many of these other fringes relate to a physician's and his family's health protection, so they are of real planning concern even beyond the usual tax-saving considerations. The fringes so relating to health care are:

- Health insurance
- Medical/dental expense plan
- Disability insurance

As an opportunity for incorporated physicians to review their own arrangements, let us explore some of our observations about the three named fringes. They are all important enough to deserve attention.

1. Health Insurance

This insurance is so basic that no doctor should be without it, and only rarely do we see one without some sort of coverage. Nevertheless, many physicians are unwittingly poorly insured against serious illness.

Some doctors have only the basic health insurance provided by Blue Cross/Blue Shield or its equivalent. Many of those basic policies fail to provide sufficient coverage against catastrophic medical expenses—the risk for which a physician most needs protection. Many "Blue" plans, even

some called "major medical," are alarmingly deficient in case of huge medical care costs.*

We thus feel very strongly that each physician must seek out and obtain health insurance coverage providing virtually unlimited maximums. Some group programs, such as the AMA's "excess major medical" policy, seem to offer this protection. Many plans we see, however, do not provide it.

A second concern is for the quality of the health insurance protection. A variety of health plans offered through smaller medical societies, alumni groups, and the like have the appeal of providing apparently good coverage at bargain premium rates. This may be particularly attractive since other medical policies are becoming so increasingly expensive.

In health insurance, we believe the old adage: "You get what you pay for." There is simply no way one insurance company can offer coverage equal to that of another company at a dramatically lower price. The actuarial likelihoods of illness, injury, and soaring health care costs cut across all classes of people too much to permit the premium variations.

This truism has led to a near impossibility—the purchase of an individual, commercial health insurance policy. Each company offering such individual insurance has raised rates and dropped

Messrs. Beck and Kalogredis are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd, Pa.

*The Medical Society of Delaware's plan, when the diagnostic and therapeutic and the catastrophic riders are chosen, does offer this coverage.

out of the market, leading one to question where equivalent protection can be obtained.

Group health insurance, purchased by a corporation* for all its regular employees, will often be the best answer. Excellent quality coverage, often with unlimited maximum benefits, is becoming a striking feature of those insurance companies which heavily promote group programs.

In many cases, such health coverage can only be obtained as part of a group term life insurance program through that insurer. Purchasing the life insurance may, however, be a cheap "price" to pay for the medical plan—and the group term life coverage may nevertheless be quite valuable in and of itself. Many companies require low limits of life insurance, perhaps only \$10,000 per doctor and less for staff, so that its purchase will be a fairly moderate way to qualify for the health insurance program.

The greatest "cost" of a physician's obtaining health insurance through a group term life program might be the requirement to cover all full-

*The group insurance can also be obtained by a partnership or unincorporated solo practice although this possibility is often overlooked.

time employees. Unless most assistants have families covered by other sources (typically through husbands' employments), this cost could be substantial. Nevertheless, since health insurance is fast becoming the single most important benefit required by employees, its offer may be necessary and/or proper anyway.

Various approaches can be taken to contain a corporation's cost of providing the health coverage. As one possibility, the premium payments could be limited to a fixed percentage of each employee's salary as part of an overall "medical/dental expense plan" (discussed below) so expenditures above the limit would have to be paid by the employee. The physician's far higher salary would provide his full premium cost, but the same percentage of other salaries would require employee co-payment.

Furthermore, most group insurers permit exclusion of some employees. This would often permit excluding some or all married assistants whose spouses already have family health coverage, while the lower cost of providing single

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persons' coverage to the remaining unmarried assistants should be acceptable. So long as the exclusions are determined in some consistent, non-arbitrary manner, the coverage and tax results should be as desired.

Professional corporation status offers the intangible advantage of better forcing doctors to focus on their health insurance programs. The premiums paid under a proper plan will be tax deductible by a physician's corporation but yet not taxed to him personally. That advantage does not extend to partnerships or unincorporated solo practices.

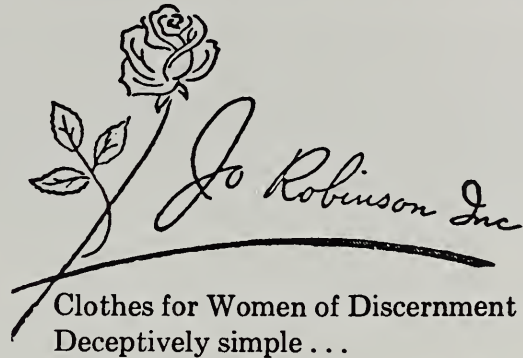
The tax-favored fringe benefit opportunity does not, however, assure a sensible decision as to the medical insurance actually obtained. We hope our observations have helped cause a critical review to assure that the coverage is as good as each physician requires and deserves.

2. Medical/Dental Expense Plan

A plan whereby each qualifying employee's medical, dental, optical, prescription drug, etc. expenses (for the employee and his/her immediate family) will be paid by the employer is a unique advantage of professional incorporation. As to a physician, those expenses will not usually be tax deductible personally; but they will be tax-favored if paid through the corporate plan. The opportunity should not be ignored.

We nevertheless find professional corporations which have not adopted such plans for dubious reasons. Some doctors have believed that a plan must cover all full-time employees (physicians and staff), which is simply not true. Tax law requires that a medical/dental expense plan be adopted "for employees" without specifying what employees and to what extent. While the requirement makes it useful to cover more than just the physician-shareholder(s), considerable leeway remains.

A corporation having one or more physicians who are not shareholders could, for example, provide coverage to all its physicians—a class broader than its stockholders. Coverage for a young doctor joining a group can usually result in an informal "trade-off" by setting his salary with the likely medical/dental benefit in mind.



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Similarly, a group might have an office manager, key senior assistant(s), or physician's assistant(s) who can and should be extended the benefit without covering all other staff.

Another approach is to cover all full-time employees but to limit the amount which may be spent for each employee each year. A limit of 5% of his/her salary would, for example, provide only \$364 of payments for a \$140 per week assistant, but it would permit payments up to \$3,000 for a \$60,000 salary doctor. Furthermore, if Blue Cross/Blue Shield or other medical insurance is provided each employee requiring it (as discussed above), the plan might include those premiums as part of each employee's expenses covered by the 5% plan—further reducing the cost for staff while leaving leeway to cover the physicians' expected uninsured expenses.

A variety of other approaches is possible. Given these cost-saving possibilities, the incorporated physician should find a medical/dental plan extremely useful. And to the extent it be-

stows some benefit on the practice's assistants, the employee relations "goodwill" should be worth the cost.

Other incorporated groups have rejected medical/dental plans for a different, but usually unsound, reason. They believe that the variations in expense payments for each physician-member will interfere with their existing approach to dividing their practices' incomes. An equal partner with no minor children and only minimal annual expenses will, for example, feel short-changed if his other partner has three children undergoing orthodontic treatment.

In some cases, we believe groups should simply recognize year-to-year variations as acceptable burdens. The medical/dental expense payments would thus be treated as true practice expenses which are likely to even out over the years. A doctor whose family incurs few expenses one year might have them another year, and the practice will assume them for whichever doctor "gets hit." So long as the plan contains a maximum limit acceptable to all doctors, this might be satisfactory.

In other cases, however, the possible variations will concern the members enough that they cannot be ignored. The group might then keep an informal record of each doctor's expense level, and in determining any general bonuses and/or succeeding year's salaries the variations could be taken into account. While this approach should definitely not be formalized, many groups have the faith and flexibility to consider the medical/dental experience among their compensation factors.

At any rate, the opportunity should not be ignored. An incorporated solo physician in the 50% tax bracket who has \$2,000 of medical/dental expenses, presents an oversimplified but common example. Setting his salary \$2,000 less than otherwise so the amount can instead be used to pay his expenses will save him \$1,000 of tax—at no loss of usable cash. The objections sometimes raised and discussed above should not overcome that savings opportunity.

3. Disability Insurance

While we find some doctors to be "over-in-

sured" as to life insurance, very few of them seem to have a sufficient amount or quality of disability (income continuation) insurance coverage. Yet statistics show that a person aged 40 is three times as likely to suffer a long-term disability as he is to die in that year. We thus feel disability insurance deserves far more emphasis than it tends to receive.

As with health insurance, a person has some choices as to disability coverage. He may buy privately sold, "non-cancellable" insurance at a fairly high premium (which rate will not increase over the years); or he may purchase inexpensive "association group" coverage through his medical societies, such as the Medical Society of Delaware has, alumni associations, etc.

The risk of cancellation is important enough that doctors should avoid purchasing the insurance through small group plans. Large associations like the AMA and state societies will have the "clout" to prevent cancellation,* or else require that a successor insurance company cover all previously insured members. Smaller specialty societies, county associations, and alumni groups are unlikely to have enough members to wield this type of leverage. Therefore, we recommend purchase of "association group" coverage only through state medical societies.

Even so, the low price of association group coverage implies lower quality coverage. The test of disability insurance should not be how cheap it is but whether the company will pay quickly and willingly upon a policyholder's illness. This will vary considerably among companies, and the lower price of mass coverage sometimes carries with it a lesser certainty of actually collecting.

The advantage of the more expensive, private "non-cancellable" insurance is its excellent quality coverage. Three or four companies have particularly outstanding reputations for realistic policy definitions, generous provisions concerning partial return to work, and responsive handling of actual claims. In our view, a physician should have this coverage despite its higher cost.

We favor a physician's "mixing" some expen-

*The Medical Society of Delaware's disability insurance plan is non-cancellable.

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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sive non-cancellable coverage with some cheaper (but good) association policies in his disability portfolio. The expensive policy or policies would be his basic, essential protection, while the group insurance would enable him to augment it at an acceptable cost. If he prospers, and especially if his retirement plan grows sufficiently to give him greater financial security, he could drop the association policies as their rates increase with his age. The basic "non-can" protection would, of course, not increase in cost as he grows older.

A professional corporation may adopt a plan to carry disability insurance for its employees. This approach presents a tax-saving advantage for an incorporated doctor—the deductible corporate payment of his premiums for his benefit. But it also presents a potential future disadvantage, for any benefits he receives upon disability will be taxed as income to him if the policies were carried or financed by his employer corporation.* They would not be taxable to him if he paid the premiums personally.

We often recommend a mixing of corporate and personal premium payment to achieve best tax advantage. The corporation might carry the expensive "non-can" policy, thus obtaining tax deductibility for the major portion of a doctor's total disability insurance costs. In case of illness, the income tax on that policy's monthly benefits would probably not be at such high rates—those benefits probably being the only major source of taxable income after just a few months' absence. On the other hand, the doctor's personally paying the cheaper association premiums will not be too serious from a tax standpoint; but in case of illness those benefits will not pile as further taxable income (at higher tax rates) on top of the other taxable benefits.

We are strongly opposed to a corporation's purchasing and owning disability insurance on a uniform basis for each of its physicians. This seems to be a favorite insurance approach, designed partly to assure that future physician-members must similarly be covered through the

*A popular "gimmick" is under some discussion, but we have no faith in it. The doctor would personally pay the premiums during the year and, if he does not become disabled, have the corporation reimburse him at year-end. While it is suggested that receipt of disability benefits during the year would thus be non-taxable as not employer-provided, we are convinced the argument will not stand IRS scrutiny. Various accountants have told us that they could not ethically avoid reporting the benefits as taxable in such circumstances, and we agree with them.



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same agent. Rather, a corporation should simply adopt a plan whereby it will pay directly (or reimburse) a doctor's premiums on whatever policies he wishes to carry. Each doctor will thus have the freedom and flexibility to obtain the insurance which best suits his own financial circumstances, for there is no reason to assume that those circumstances will always be similar for different members of the same group.

A corporation plan might express its undertaking to pay directly or reimburse each physician-employee's disability insurance premiums up to some specific percentage of his basic salary. For a \$60,000 per year doctor, a 2% or 3% plan would permit fairly ample flexibility to run one or two expensive "non-cancellable" policies through the tax-favored route. The cheaper policies could still be paid personally by the doctor and not be involved in the corporate plan.

As with medical/dental expense plans, disability insurance (termed accident and health insurance in the tax code) must also be under a plan "for employees." Providing it only for the physician-shareholder(s) presents the same tax risks, and broadening the plan's coverage to other employees would be very helpful.

Some doctors actually provide shorter term disability coverage for all full-time staff as a self-serving but valuable fringe benefit. The cost of such coverage (sold through some medical societies under the sexist term "Girl Friday insurance") is quite low, and yet it can justify reducing the length of time a practice will pro-

vide sick pay in case of an assistant's illness. In one example we found the insurance cost would be offset if just one employee were absent for three weeks once in three years.

As another possible approach, disability insurance premiums might be lumped into the medical/dental expense plan. Thus, a single plan covering all employees (physicians and staff) up to 5% of each person's salary could provide for all three of the discussed fringes: medical (health) insurance, disability insurance, and uninsured medical, dental, etc. expenses. For the \$60,000 a year doctor, \$3,000 of such allowance may meet all his needs, while the cost of covering an \$8,000 a year secretary will not be too costly. And he may thus not have to provide disability insurance for his staff since they might instead use their 5% allowances otherwise.

4. Conclusion

While not the primary incorporation item, the health-oriented fringe benefits offer real tax-saving opportunities. Misuse of them can result in costly income tax results, so careful advice and planning are important.

Even more essential, the proper health benefit programs are essential to a physician and his family. Failure to have the right insurance coverage can, for example, result in real financial catastrophe. We hope this article helps each reader evaluate his own personal arrangements, with the professional corporation facilitating intelligent and yet tax-saving decisions.

PHYSICIAN COMMENT SOUGHT ON CHANGES IN ETHICS CODE

The American Medical Association is seeking comment from American physicians regarding proposed revision of the AMA's Principles of Medical Ethics.

The amendments proposed by the AMA Judicial Council are intended to modernize the language of the Principles and to clarify their meaning. The changes are on the agenda of the AMA House of Delegates for the Annual Convention in June, 1978, in St. Louis.

Comments and suggestions should be addressed to: Medical Society of Delaware, 1925 Lovering Avenue, Wilmington, Delaware 19806 and mailed by March 27.

Following are the present Principles of Medical Ethics and the proposed new version of the Principles.

PRESENT PRINCIPLES OF MEDICAL ETHICS

Preamble. These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1. The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man.

Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2. Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3. A physician should practice a method of healing founded on a scientific basis; and should not voluntarily associate professionally with anyone who violates this principle.

Section 4. The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

PROPOSED NEW PRINCIPLES OF MEDICAL ETHICS

Preamble. These principles are intended to aid physicians in maintaining high standards of ethical professional conduct in their relations with patients, colleagues, members of allied professions, and the public.

One. The primary objective of the medical profession is to serve patients competently with full respect for their dignity.

Two. Physicians should strive continually to improve medical knowledge and skill and to make available to patients and colleagues the benefits of their professional attainments.

Three. A physician should not engage or participate in treatment which is not founded on a scientific basis.

Four. The medical profession should protect the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of their profession, and voluntarily accept its self-imposed disciplines. Physicians should expose, without hesitation, illegal or unethical conduct of members of the profession.

PRESENT

Section 5. A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6. A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7. In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies, or appliances may be dispensed or supplied by the physician provided it is in the best interest of the patient.

Section 8. A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9. A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10. The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and well-being of the individual and the community.

PROPOSED

Five. Physicians may choose when they will serve except in emergencies. Competent services should be provided and continued until the physician is discharged or services are discontinued after giving adequate notice. A physician should not attempt to obtain patients by deception.

Six. Physicians should resist restraints which interfere with medical judgment and skill or cause deterioration of the quality of medical care.

Seven. Physicians are entitled to be compensated fairly for personally providing or supervising the medical care of patients. A commission should not be paid nor accepted for the referral of patients.

Eight. A physician should seek consultation upon request or whenever it may benefit the patient.

Nine. A physician may not reveal confidences entrusted during medical attendance or deficiencies observed in the character of patients, unless required to do so by law or it becomes necessary in protecting the welfare of the patients or the community.

Ten. In addition to providing care to patients, the physician has a social responsibility to participate in activities intended to improve the health of the community.

Editorials

THE UPDATED INTERNIST

In a recent editorial in the *Delaware Medical Journal*, Dr. Vandervort asked, "Where is the internist?" He is concerned that a number of internists, whom he had known over the years, are no longer involved in classical primary care practice.

Perhaps, in answer to him, it will be worthwhile to review the history of internal medicine in Delaware as I have seen it. If I use the development of a residency program as a sign that internal medicine was coming of age, the post-World War II years become a reference point. During World War II, Dr. Lewis B. Flinn, Dr. H. Wendell Gray, Sr., Dr. Edgar Miller, Sr., Dr. B. B. G. Blackstone, and a few others held the fort, especially in hospitals where the increasing complexity of medical care demanded more time and effort than when they served mostly a surgical population.

Dr. Flinn, after his primary training in internal medicine at Hopkins in the early 1920s followed by pediatrics at the Children's Hospital in Philadelphia and chest diseases at Colorado Springs, became the leading internist in Delaware during and after World War II. He helped establish the residency programs at the Delaware and at the Memorial Hospitals. Dr. Ward Briggs, Dr. Henry Clagett, Dr. Richard Durham, Dr. Lemuel McGee, and Dr. Joseph Messick were the board-certified teaching staff, but they had significant help from others with hospital-based training who had gained recognition through experience. These included Dr. Fred Bowdle, Dr. Gray, Dr. E. M. Krieger, Dr. Charles Levy, Dr. Joseph Barsky, Sr., Dr. William Urie, Dr. Eugene Gaumer, Dr. Shermer H. Stradley, Dr. Gerald Beatty, Dr. Charles Bancroft, and Dr. John Barnhart.

The period which I know first-hand began with my residency in 1947 at the Memorial,

where Dr. Irvin Carroll was the chief resident. Dr. James Flanders and Dr. Allston Morris were concurrently at the Delaware. Over subsequent years, a large number of the internists now practicing in town were residents in the Delaware or at the Memorial. Dr. Leonard Lang became Chief of Medicine at the Memorial around 1952. Dr. Flinn continued at the Delaware until about 1960, when Dr. Barrett Heckler took over. Drs. Heckler and Lang remained the chiefs of these respective services until merger of the separate hospitals into the Wilmington Medical Center in 1966. I was chief of the merged medical services from 1966 to 1972.

During the late '40s, '50s, and early '60s, at least a dozen internists started to practice in Wilmington including Allston Morris ('49), James Flanders ('50), John Benge ('51), Charles Walker ('51), Marvin Dorph ('52), Barrett Heckler ('52), William Holloway ('52), Jack Sallee ('53), Bob Wuertz ('53), Alfred Bacon ('55), I. J. Tikellis ('55), William Vandervort ('55), James Hofford ('56), Bernadine Paulshock ('56), Stanley Verbit ('56), Oleh Sluzar ('57), Joyce Anderson ('57), Gerhard Hartenauer ('59), Gustav Berger ('61), Richard Kahlbaugh ('62), Rudolph Nyhoff ('63), and Charles Riegel ('64). In the mid-to-late '50s, because of our graduate residency program, more sub-specialists entered practice, although cardiology (Dr. Clagett and Dr. Durham), gastroenterology (Dr. McGee), allergy (Dr. Bancroft), and chest diseases (Dr. Beatty) were already established as specialists. Dr. Dewey A. Nelson came in neurology in 1956, Dr. John Egan in hematology in 1957, and Dr. Robert B. Flinn in nephrology in 1963.

The whole character of medicine has changed considerably since then. In the '50s, the internist expected to be the "compleat" physician in almost all sub-specialties, except possibly cardiology. In 1965-66, with the development of

the current merged residency program, the general internist seemed to be pushed into the background. He no longer was called in first by the house staff for special problems, such as in cardiology, hematology, nephrology, or neurology, where sub-specialties were available. This loss of recognition may have led a number of the internists to take on other types of jobs, although the demanding nature of internal medicine has to be considered. It is not an easy life to try to keep up academically and to be available on 24-hour call, seven days a week for all types of problems.

In the early 1950s, internal medicine had difficulty establishing an identity. In most people's minds, an "internist" was a modified intern, and the term was not well recognized, even within the profession. The American College of Physicians was the chief professional organization of the internist who was academically oriented and was not interested in looking at problems faced by internists in community practice. The American Society of Internal Medicine was organized to help the practicing internist achieve a sense of identity, a fiscal return for his extra skills and work, and a recognition in the market-place and society as a significant member of the health team. The concept of the internist as the "captain of the ship" was very much in evidence.

With the increasing prominence of the internist, the general surgeon, and the obstetrician as specialists, the family practitioner often felt lost in the late '40s and early '50s. It was hard for the average patient to know the difference between an internist and a family practitioner. I have always preferred to call the internist, the pediatrician, and the family practitioner, "personal physicians," since this term seems to describe their common activities. The family practitioner usually covers a wider age range within the family and often includes obstetrics, while the general internist and the pediatrician develop more in-depth experience for the respective problems of the adult and the child.

With the development of the Academy of Family Physicians, the Family Practice Boards, and Family Practice residency program, the family practitioner achieved renewed status, but

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the "captain of the ship" internist often found his position hard to distinguish from the family practitioner's, especially as his consultative practice was largely taken over by the sub-specialties.

The medical residents of 1978, who look forward to private practice where they can manage patients with diabetes, coronary disease, chronic leukemia, etc., recognize that patients in most cosmopolitan communities will often prefer to be seen by sub-specialists. Therefore, they are hesitant to become primary care internists vs sub-specialists. Many are entering sub-specialty fellowship training with a real reluctance to drop other aspects of internal medicine and with the hope that they can find a practice situation where they can act as primary general internists and still carry on in some sub-specialty, a combination which works well in some communities but which may be difficult in large ones. Sometimes, however, this is the only way, with the multiplication of sub-specialties, that the internist with sub-specialty training can see enough patients to make a living, even in large com-

munities. This problem is not just one of economics. There is a real joy in the care of and responsibility for patients with general medical problems, which a consultant never quite gets unless he becomes the primary physician for a patient with his particular problem. Even then, he seldom gets to know the whole family in the same way that the "personal physician" does.

The resurgence of the family practitioner has certainly been needed, and is a healthy development. It is too bad that some of the programs in primary care seem to be on collision courses. The American College of Physicians still does not recognize Family Practice Boards as a specialty board to qualify for admission to the College, although there is nothing in the College by-laws, except Regents' approval, to keep this from happening. There is also pressure for other subspecialties such as emergency care and critical

care. This creates new problems. The cardiologists wonder whether they or the critical care specialists in intensive care units should properly take qualified care of the cardiology problems seen there. Similarly, who is best qualified for acute care problems in hematology, neurology, nephrology, etc., etc.?

Some experts suggest that the master "consultant" of the future may be the computer. Dr. Jack D. Myers, Past President of the American College of Physicians, Emeritus Professor of Medicine at the University of Pittsburgh, has been helping program a computer with at least four times his knowledge. He anticipates it should go to ten times or more before he is finished. It does a very good job of solving *New England Journal* CPC's. The gastroenterologist would probably question whether the computer is going to be able to look down the

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gastroscope. Others, of course, will also question whether a computer can examine the patient or answer a phone. But the computer may still become a valuable resource for the personal physician. Some of the fear expressed by those in primary care that they may be held legally liable, or be shunted aside by government edict (as we have seen happen in Army medicine) if they care for "sick people" without sub-specialty help, may be quieted by computer-type consultations. It is difficult in 1978, however, except in isolated communities, for a personal practitioner to give the patient all the benefits available from a whole team of medical and paramedical professionals.

How should present and future residents in medicine be advised about extra training as general internists, or as sub-specialists? Recent residents have included some who have gone into general internal medicine happily and successfully, such as Drs. Roger Thomas, Jr., William Renzulli, Robert Brereton, Athena Nicholas, William Nicholas, Charles Hill, Mike Peters, Roger Stevenson, Tomas Kuon, Tom Celello, Herbert Heym, while others like Drs. William Taylor, Chris Donoho, and Russ Labowitz are recognized as sub-specialists. It is obvious that both types of doctors are needed to work as a team. The team approach will probably be more frequently used in the future with the personal physician acting as the coordinator or captain. The patient needing multiple consultations may be able to consult a "pain" team, a "cardiac-surgical" team, or an "advanced disease" team (such as we have in cancer, with a surgeon, a radiotherapist, an immunologist, and a chemotherapist).

Communication skills will be needed to include patients in management decisions. Multi-disciplinary care, including the computer and sub-specialists working together with the personal physician, is needed with the increasing knowledge and sophistication characteristic of modern medicine. The touch of the personal physician is needed. He must call the signals and steer the patient. The personal physician is the catalyst, as well as the advocate within the *team* for the patient. This is the updated internist sought by Dr. Vandervort.

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Book Reviews

INFLUENZA—THE VIRUSES AND THE DISEASE
by Sir Charles H. Stuart-Harris and Geoffrey C. Schild, Publishing Sciences Group, Inc., Littleton, Massachusetts, 1976. 242 pp. Illus. Price \$22.00.

The authors provide a reason for such a book in the preface: "The decision to write a monograph on a single human disease can only be justified when knowledge has grown to such an extent that a general text-book cannot, for lack of space, give it adequate consideration." The challenge of influenza, "the last of the Great Plagues," well merits such an effort.

For the person interested in all aspects of influenza, the book can be read with enjoyment and value in its entirety; however, for those with more specialized interests the well-referenced chapters can be read individually for subjects of interest.

The human disease referred to as an "unchanging disease due to a changing virus" is discussed in Chapter 5. The statement is not quite true, for the morbidity and mortality patterns do vary from outbreak to outbreak and even from country to country in a given epidemic. The following two chapters cover the epidemiology of the disease and serve to emphasize how little is really known as to the origin, timing, and severity of the next influenza outbreak. Only one thing appears certain: in spite of all efforts, influenza epidemics will be back.

The chapters on vaccines provide a well balanced discussion of different types of vaccines, their activities, and shortcomings, and the possible role of vaccines in modifying further influenza epidemics. In spite of up to 80% efficacy of the best and most potent vaccines, the outlook is not optimistic that these will provide a great effect on the outbreaks because of this changing virus.

Chemotherapy of influenza is discussed in Chapter 11. Amantadine HCl, the only drug available for influenza A, is covered from the point of view of both prophylactic and thera-

peutic activity. More stress is given to the smaller studies carried out in Great Britain than those carried out in other countries. Ribavirin is covered; however, because of the timing the results of clinical trials, some positive, some negative were not discussed. In such a rapidly changing area it is difficult for a monograph to be current.

Chapter 3 contains an informative description of the antigenic drift and shift of influenza viruses and the modern nomenclature systems, used to keep up with this constantly changing virus. It should be read by everyone wishing to understand the reports and recommendations issued by the Center for Disease Control in the USA and the WHO worldwide.

This book answers many questions, but emphasizes that influenza is still well ahead of all efforts for its control.

CONRAD E. HOFFMANN, PH.D.

Dr. Hoffmann is Manager Microbiology of the Pharmaceuticals Division at the Stine Laboratory of E. I. duPont de Nemours & Company.

COLOR ATLAS OF GENERAL SURGICAL DIAGNOSIS by William F. Walker, DSc, ChM, FRCS, FRSE, Year Book Medical Publishers, Chicago, 1976. 448 pp. Illus. Price \$37.95.

This volume is a pictorial presentation of a large variety of surgical conditions and is not a comprehensive text. It may be used as a companion to the large volumes detailing surgical methods. The color photographs are well done and will provide, to the general practitioner and internist as well as the surgeon, an interesting compilation of conditions which may commonly be encountered in practice.

Short descriptions of the photographs are found in the immediate proximity of the photo. One could wish for a slightly lengthier description of the condition presented but, as mentioned previously, this is not a general surgical text. It was obviously not intended to cover every

conceivable surgical condition, but it does include a few rare conditions.

ETHAN FLAKS, M.D.



NEONATAL AND PEDIATRIC CARDIOPULMONARY CARE A SELF-ASSESSMENT by Thomas J. Williams, G.S., A.R.R.T., Year Book Medical Publishers, Inc., Chicago, 1976. 214 pp. Price \$7.95.

This is a compendium of questions directed mostly at paraprofessionals and is too simple to benefit the average physician.

It seems complete and might be helpful as a quick review of basics for those working in a neonatal or pediatric intensive care unit.

EDWARD W. McREYNOLDS, M.D.



UROLOGY IN PRIMARY CARE by Stephen N. Rous, M.D., M.S., F.A.C.S., The C. V. Mosby Company, St. Louis, 1976. 278 pp. Illus. Price \$11.75 paperback.

Dr. Rous explains in his preface to the book that it is not intended as a comprehensive text on the field of urology. Instead, its purpose is essentially to outline the spectrum of urologic problems to the primary care physician and the medical student.

With this purpose in mind, Dr. Rous does fulfill his goal; however, since many urologic problems are commonly dealt with by most physicians, much of the information provided by the text falls far short of providing any new information to most physicians and, in fact, takes a much too simplistic view.

For example, the chapter on gram-negative sepsis and septic shock covers three pages. Surely, this is inadequate to cover even an introduction to the topic. The same can be said for the chapters on antibiotics and renal transplantation and dialysis. These do little more than mention that they exist.

The information provided on benign prostatic hypertrophy and intrascrotal problems, however, has much to offer and is well written. Especially helpful were the chapters on urine findings and

diagnostic procedures used in urology. Here, the illustrations provided are excellent and offer good information to the non-urologist which he can apply to his practice.

Considering that most clinicians have no text on urologic problems in their library, this book may be a useful addition; however, for more detailed coverage of this field, an alternative, more comprehensive text should be sought.

THOMAS M. MANNIS, M.D.



TREATMENT OF INJURIES TO ATHLETES, 3rd edition, by Don H. O'Donoghue, M.D., W. B. Saunders Company, Philadelphia, 1976. 834 pp. Illus. Price \$27.50.

The latest edition of O'Donoghue's book remains a front-runner in sports medicine. Anyone who is at all interested in treating athletes and their injuries should have the book for reference. All team physicians should be familiar with its contents.

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O'Donoghue has been called the father of sports medicine for over 20 years. His textbook has provided an adequate background for the specialty of sports medicine for almost as long. His inclination, of course, is that of an orthopedic surgeon with emphasis on surgical correction of already present injuries. Preventive care, training room techniques, aggressive non-surgical therapy, and consideration of the newer non-steroidal anti-inflammatory agents along with other medical therapy, are all partially neglected. The medical sports physician would be refined in these areas anyway and would be able to filter through O'Donoghue's abbreviated dictums for medical management. (For example, O'Donoghue discusses po enzyme use as if its efficacy were unquestioned.)

The surgical discussions, however, are readable, concise, and well thought out; they provide a logical source of back-up information for the family physician, the internist, or the pediatrician who is into athletic medicine. The non-surgeon sports physician should find this text a useful

supplement to his knowledge of an area where his training may be limited.

The surgeon who treats athletic injuries would do well to review O'Donoghue's treatment concepts *and* philosophy. There are definite differences in proper management of many identical injuries in athletes versus non-athletes.

For those physicians who use more than a handful of books for reference, this title should be included.

JOHN E. HOCUTT, JR., M.D.

✻ ✻ ✻

TWO CENTURIES OF AMERICAN MEDICINE 1776-1976 by James Bordley, III, M.D. and A. McGhee Harvey, M.D., W. B. Saunders Company, Philadelphia, 1976. 884 pp. Illus. Price \$19.76.

This book is an outstanding literary achievement! It should certainly be available in every reference library, non-medical as well as medical. The authors have been steeped in clinical medicine, research, and historical pursuits for many years and are therefore especially able to present two centuries of American Medicine most ably in the manner they set out to do as stated in the Preface: "to relate in language that can be understood by the interested layman, as well as the physician." The detailed account of many of the discoveries and erudite investigations are clearly stated in a readable form without quoting statistics, mathematic equations, or complicated chemical formulae. Such scientific information can be found in the very adequate list of references for each chapter recorded in the back of the book. Appendix B, a Chronological summary of major events in American medical history, is interesting reading in itself.

The book is divided into three parts. Part one, 1776-1876, describes the customs and culture or lack of culture of these first hundred years as a backdrop for the gradual change from the primitive medicine of that era. Part two, 1876-1946, recounts the great crescendo of progress in all aspects of medicine. Part three expounds many details of this explosive period with the more recent advances in genetics, immunology, and molecular biology.

Many will cherish this volume in their own personal libraries. It is, however, a very heavy, unwieldy book. Perhaps it might have been better had it been published in two or three volumes. One very attractive feature throughout the text, especially at the start of each chapter, is the insertion of appropriate quotations from outstanding and celebrated authors, scientists, physicians, and statesmen such as Thomas Jefferson, William Henry Welch, William Osler, James Howard Means, Vannevar Bush, William Harvey, Edward Jenner, Louis Pasteur, Victor A. McKusick, Nathaniel Hawthorne, Alan Gregg, Harold Himsworth, and many others.

The illustrations and photographs are many and well placed. The authors admitted that they were somewhat biased in choosing some of the subject matter and felt that they could not cover everything in detail such, for instance, as bone pathology and related diseases. Nevertheless although they are both intimately connected with Johns Hopkins, they should be congratulated on their ability to avoid being insular and in being able to present the subject in a very broad scope.

LEWIS B. FLINN, M.D.

❖ ❖ ❖

MOMENT OF INSIGHT: VIGNETTES FROM A PSYCHOANALYTIC PRACTICE by Sumner L. Shapiro, M.D., International Universities Press, Inc, New York, 1976. 119 pp. Price \$8.50.

A psychoanalyst, Dr. Shapiro clearly outlines his purpose for writing this book in his introduction. He says, "I sought a way . . . to clarify some misconceptions and speak out. I wondered, could there be some manner in which I might take the public in behind my couch and desk to have a firsthand glance at what I do and why?"

The book consists of nine psychological short stories based on patients that Dr. Shapiro has treated. He is a very good storyteller, making the book entertaining and quite readable. In a subtle and interesting way, Dr. Shapiro has accomplished what he intended to do in writing these stories. The book is good reading for both professionals and nonprofessionals interested in the finer workings of human nature.

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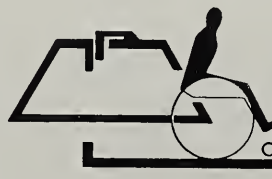
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MEDICAL SECRETARY'S MANUAL by Myreta Eshom, M.A., Appleton-Century-Crofts, New York, 1977. 562 pp. Price \$15.00.

This turns out to be a manual for secretaries who take shorthand. An experienced secretary (jms) in our office concluded that "it would probably make an excellent tool for teaching medical shorthand but is not necessary for most medical offices now because of the almost universal use of dictating equipment. The book does have a great index." The latter allows it to be used as something more than a dictionary since related words and their definitions, as well as their shorthand symbols, are found on the same page, and the chapters are subdivided by body systems.

BERNADINE Z. PAULSHOCK, M.D.

THE NATURAL WAY TO SUPER BEAUTY by Mary Ann Crenshaw, Dell Publishing Company, New York, 1975. 432 pp. Price \$1.75 paperback.

This paperback reads like the perils of Pauline. Miss Crenshaw, as she states, "has written from her own (painful) personal experiences." There is obviously some merit in much of her writing with reference to supplemental or dietary vitamins, hair care, and physical exercise; however, like many authors of this type of fare, she has a tendency to get carried away with Vitamin E, Laszlo facial douches, and similar nefarious routines. In its paperback form, it makes good reading for the distaff side on a lazy beach under an umbrella.

PETER R. COGGINS, M.D.

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In Brief

Speakers on "Ask the Doctor"

Speakers for March 1978 on the Tuesday radio program (11:05 a.m., WDEL) produced by the Medical Society of Delaware are: March 7, *Christopher R. Donoho, Jr., M.D.*, Gold Treatment of Arthritis; March 14, *David King, M.D.*, Cerebral Palsy; March 21, *Bruce E. Matthews, D.D.S.*, Children's Dental Health; March 28, *Henry H. Stroud, M.D.*, Developmental Pediatrics.

In the News

Bayard R. Vincent, M.D., of Wilmington, has been reappointed by Governor duPont to the Council on the Blind. Governor duPont reappointed *William J. Holloway, M.D.*, Wilmington, to the Delaware Drug Advisory Board. Their terms end January 10, 1981.

Advance orders for daffodils are being taken now for Daffodil Day, March 17. Daffodils are \$2.50/bunch. Contact the American Cancer Society, Wilmington, 654-6267.

New Professional Journal

A new interprofessional journal, *Evaluation and the Health Professions*, will be available in the spring of 1978. The journal is designed to serve as the forum for all health professionals interested in or engaged in the development, implementation, and evaluation of health programs. The multiprofessional quarterly is designed to encourage and facilitate the expanding role of evaluation in *all* of the health professions. Subscriptions are available through Empirical Publications, Inc., P.O. Box 13345, Baltimore, Maryland 21203.

CLINICAL NOTICES AND MEETINGS

Breast Cancer Conference

The American College of Radiology will sponsor THE 17th ANNUAL NATIONAL CONFERENCE ON THE DETECTION AND TREATMENT OF BREAST CANCER, March 6-9, 1978, in San Francisco. Cosponsors are the College of American Pathologists and the Educational Foundation of the Society of Plastic and Reconstructive Surgeons, in cooperation with the American College of Obstetricians and Gynecologists. The Conference will feature internationally recognized authorities in the fields of radiology, surgery, pathology, epidemiology, and other medical and non-medical specialties. Approved for 29 hours of Category I credit, and 18 ACOG Cognates. For information contact: Breast Cancer Conference, ACR, 6900 Wisconsin Avenue, Chevy Chase, MD 20015.

Ophthalmology Related Courses

The American Association of Ophthalmology reports that the following courses and/or meetings related to Ophthalmology will be held during the months of March and April: 18th ANNUAL INSTRUCTIONAL COURSE IN CONTACT LENS FITTING BY THE OPHTHALMOLOGIST, March 9-11. Contact: Rudolph Ellender Medical Foundation, Inc., Roof, Delta Towers, New Orleans, LA 70112. Telephone: (504) 524-9729. THE SECOND ANNUAL OPHTHALMOCRYOSURGICAL SEMINAR, March 11-12. Contact: Rudolph Ellender Medical Foundation, Inc., Roof, Delta Towers, New Orleans, LA 70112. Telephone: (504) 524-9729.

In Brief

INDIRECT OPHTHALMOSCOPY AND PERIPHERAL RETINAL DISORDERS, March 10-11. Sponsored by the Department of Ophthalmology and the Page and William Black Postgraduate School of Medicine of the Mt. Sinai School of Medicine. Contact: Director, The Page and William Black Postgraduate School of Medicine, Mt. Sinai School of Medicine, One Gustave L. Levy Place, New York, NY 10029. Telephone: (212) 650-6737.

INTRAOCULAR LENS SYMPOSIUM, March 14-18. Contact: The American Intra-Ocular Implant Society, P.O. Box 3140, Santa Monica, California 90404. Telephone: (213) 395-3937.

THIRD ANNUAL NEW ORLEANS SPRING FIESTA OPHTHALMOLOGY SEMINAR, April 13-15. Sponsored by the Azar Foundation and Tulane Medical Center. Contact: Robert E. Azar, M.D., Program Chairman, 144 Elk Place, Suite 1501, New Orleans, LA 70112.

ANNUAL GLAUCOMA COURSE, April 14-15. Sponsored by the Glaucoma Service of the Wills Eye Hospital. Contact: Kenneth Benjamin, M.D., 1419 Spruce St., Philadelphia, PA 19102. Telephone: (215) 546-2412.

DAFP Annual Meeting

The 26th Annual Meeting and Annual Scientific Assembly of the Delaware Academy of Family Physicians will be held March 7 and 11 at the Delaware Academy of Medicine, Wilmington. The topic of the March 11 Scientific Assembly will be **NUTRITION—FOOD FOR THOUGHT: FOOD FOR HEALTH**. Non-physicians are also welcome. For information contact: Ms. Anne Shane Bader, DAFP, 1925 Lovering Avenue, Wilmington, Delaware 19806. Telephone: (302) 658-7596.

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**Workshop on
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The Moss Rehabilitation Hospital will present the SEXUAL ATTITUDE REASSESSMENT WORKSHOP (SAR), March 10-12, Philadelphia, PA. Designed for health care workers in the field of rehabilitation, the SAR helps professionals to better deal with the sexuality of their physically disabled patients. Advance registration is required. Approved for 23 hours of Category I credit. For information contact: SAR Workshop Coordinator, Moss Rehabilitation Hospital, 12th Street and Tabor Road, Philadelphia, PA 19141.

**Financial
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Seminars Symposia, Inc. will sponsor the 1978 series of FINANCIAL MANAGEMENT WORKSHOPS. The workshops are designed to meet an important need of office-based practitioners and specialists starting a practice, in the midst of a demanding one, or nearing retirement. Approved for 12 hours of Category II credit. For information contact: Seminars & Symposia, Inc., 505 Park Avenue, New York, NY 10022. Telephone: (212) 421-3774.

March 16-19, Williamsburg, VA.

April 20-23, Mountain Shadows, Arizona.

May 11-14, Del Webb's Sahara Tahoe, Nevada.

ACP Courses

The American College of Physicians will sponsor the following courses which may be used to fulfill Category I requirements for the AMA Physician's Recognition Award. For information contact: Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, PA 19104.

CURRENT CONCEPTS IN CLINICAL ONCOLOGY, Albany, New York, April 3-5.

CURRENT CONCEPTS IN CLINICAL INFECTIOUS DISEASES, Charlottesville, Virginia, April 5-7.

LABORATORY MEDICINE, Rochester, Minnesota, April 12-14.

59th ANNUAL SESSION OF THE ACP, Boston, Massachusetts, April 17-20.

APPLIED IMMUNOLOGY: THE RHEUMATIC DISEASES, Birmingham, Alabama, April 26-28.

THREE DAYS OF HEPATOBILIARY DISEASES, Atlanta, Georgia, April 27-29.

**Rationing Medical
Care Program**

The American Society of Internal Medicine will hold their 1978 Annual Meeting, MEDICAL CARE, LTD., May 4-7, at the Hyatt Regency in San Francisco. There is no registration fee for the Annual Meeting. For information contact: ASIM, 535 Central Tower Building, 703 Market Street, San Francisco, California 94103. Telephone: (415) 777-1000.

**American Heart
Association
Programs**

The call for abstracts and scientific exhibits for the 51st ANNUAL SCIENTIFIC SESSIONS OF THE AMERICAN HEART ASSOCIATION has been issued. Official forms, advance registration, and additional information may be obtained from the Section on Scientific Sessions, American Heart Association, 7320 Greenville Avenue, Dallas, Texas 75231. Abstracts selected for presentation will be published in a supplement to "Circulation" (October 1978). Postmark deadline is May 19, 1978.

The American Heart Association will also be presenting the following programs. For information contact the American Heart Association, 7320 Greenville Avenue, Dallas, Texas 75231.

18th ANNUAL CONFERENCE ON CARDIOVASCULAR DISEASE EPIDEMIOLOGY, March 13-15, Dutch Inn and Golf Resort Hotel, Orlando, Florida.

9th ANNUAL POSTGRADUATE NEPHROLOGY SEMINAR, ALTERATIONS IN BONE AND MINERAL METABOLISM IN CHRONIC RENAL DISEASE, April 2-4, Breckenridge Inn at Frontenac, St. Louis, Missouri.

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Advertisements under the Classified Ad Section are charged at the rate of 30 words or less, set solid. One insertion \$4.00. Call the Journal office, 658-7596 for further information or placement. All advertisements are payable in advance. The Editorial Board reserves the right to edit copy. Closing date for new copy is the first of the month for inclusion in the current issue.

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cancer communiqué

FROM THE DELAWARE CANCER NETWORK*

CANCER CONTROL IN DELAWARE—AN HISTORICAL PERSPECTIVE

THOMAS C. FEDEWA, PH.D.

The Delaware Cancer Network has as a major cancer control goal the promotion of the latest and best services for cancer patients and their families at their local health care provider. The National Cancer Institute's goal in Cancer Control is stated in terms of identifying, field testing, demonstrating, evaluating, and promoting the widespread application and availability of the latest methods for reducing the incidence, morbidity, and mortality from cancer. This continues to be implemented in the State of Delaware by the work of the Cancer Control Programs of the Delaware Cancer Network.

In 1933, Douglas M. Gay, M.D., a Delaware pathologist, presented an interesting proposal for a statewide Cancer Control Program to the annual meeting of the Delaware Committee of the American Society for the Control of Cancer. The proposal serves as a good reference point for assessing the current state of Cancer Control activity in the State of Delaware.

In his proposal, entitled, "ORGANIZATION OF CANCER CONTROL PROGRAM IN DELAWARE" Gay used statistical studies done by a Dr. A. C. Jost of cancer deaths reported to the

Delaware State Department of Health during the years 1909 to 1928 inclusive. Gay stated that Jost determined a cancer mortality rate for the State of 103 per 100,000 in 1928. Gay further cited his own findings of a 1932 projection of 115 deaths per 100,000. Finally, Gay postulated that there were 828 person alive with a diagnosis of cancer in the same year. This later figure was based upon the stated assumption that morbidity from cancer was three times the mortality figure. Gay also presented the results of a cancer survey in the State done by a Dr. J. W. Cox in 1929 as a representative of the American Society for the Control of Cancer. The Cox survey indicated that the State Cancer Control Program was deficient in seven particular areas:

1. Lack of physical equipment
2. No special personnel to operate equipment
3. No laboratory facilities
4. No cancer outpatient department
5. No follow-up services
6. No system of adequate records of statistics
7. No group study of cancer patients

Dr. Fedewa is Deputy Director for Cancer Control for the Delaware Cancer Network.

*An NCI-supported agency located at 1200 Jefferson Street, Wilmington, Delaware 19801. Tel. (302) 428-2113.

Gay concluded in his remarks relating to "Facilities for Cancer Control in Delaware" that since the Cox survey, the Delaware Hospital had installed a 200,000 volt x-ray machine, engaged a full time pathologist, and installed laboratory facilities for frozen and permanent sections. The Wilmington General Hospital had acquired about 200 mg of radium, and apparatus for frozen sections was being installed in the Homeopathic Hospital in Wilmington and the Milford Emergency Hospital. He stated that the other deficiencies cited in the Cox survey remained. Further, he added that "there was no program of public education regarding cancer and there was very slight effort to increase the education of physicians in the subject."

Such historical material helps to give a perspective and a point of comparison in looking at current cancer control activities in the State. Data which is starting to be generated by the Delaware Cancer Reporting Service, one of the newer Network services, gains greater depth and meaning when compared to these earlier studies.

In 1976, for example, 1200 Delaware citizens with a history of cancer died of cancer or cancer-related causes, giving the State a mortality rate of slightly more than 200 deaths per 100,000 population. With Gay's 1933 postulate that morbidity is three times mortality, a morbidity figure of 3600 could be expected for the same year. Current data, however, strongly suggests that present morbidity approaches six times the mortality rate. The Delaware Cancer Reporting Service lists 7,460 Delawareans who have had a diagnosis of cancer since 1967 and who are alive today. Though both incidence and mortality per 100,000 have increased since the 1933 report, more people per 100,000 are surviving following a cancer diagnosis.

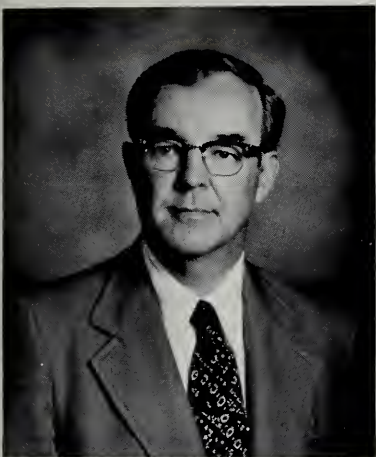
While our current data base does not yet permit a thorough study of trends, it is safe to say that the deficiencies noted by Cox and Gay have been eliminated. The use of specialized equipment for detection and treatment including Gamma cameras, xeroradiography, cobalt therapy units, x-ray therapy machines, the linear accelerator, the CAT Scan, and the colonoscope is well

known.

All hospitals in the State now have adequate laboratory facilities. Medical oncology outpatient services are now available in every non-governmental hospital in the State. Group studies of cancer patients in Delaware include those studies carried out as part of the National Cancer Institute's protocol programs. These studies are currently focused locally on leukemia, lymphoma, and cancers of the colon, rectum, and breast. In addition, specialized studies on the management of breast and colo-rectal cancers are also being carried on under the auspices of the Cancer Network. Follow-up services are in place to the degree that each newly diagnosed patient is reported to the Cancer Reporting Service and the patient is followed annually by the local hospital registry contracting Physician-of-Record. A system of adequate recording of statistics is taking shape under the comparatively new Cancer Reporting Service. Extensive public education is carried on by the Delaware Division of the American Cancer Society, and physician education is accomplished by programs including the monthly conferences in the local hospitals of the Network-sponsored Tumor Control Centers Program, the Professional Education Activities of the American Cancer Society, and the DIMER Program of Continuing Education for Physicians.

The concept of multidisciplinary management of the patient has been expanded to include allied health specialties such as pastoral services, nursing services, social services, and self-help groups, such as Make Today Count, United Ostomy Association, and Laryngect Society of Delaware.

In conclusion, it is interesting to note the frequency with which the term "prevention of premature death" is being used in cancer control literature. Equally interesting is the increased emphasis being placed upon "quality of life" as opposed to "quantity of life" issues in the health services field. The Cancer Control Program in the State of Delaware has accomplished much over the past 44 years to prolong the lives of cancer patients. At a minimum, we should want to continue with the emphasis placed upon improving the quality of that prolonged life.



President's Page

WE ARE JUDGED

What is the single most important factor used by the general public in forming its opinion of the medical profession?

Would you be surprised to know it's you?

According to public opinion surveys conducted on behalf of the American Medical Association, the main source of public information about our profession is not the ones we worry most about—newspapers, magazines or TV; it is word-of-mouth.

There are now 2.9 million visits per day between patients and physicians, and the public attitude is formed overwhelmingly by that experience, not by what is said or not said by the media. It is the way in which we as individual physicians deal with people as individual patients that counts most—not what the media says that forms the overriding body of public opinion, but what we do.

Public perception of medicine is basically the vast sum of millions of small daily reactions by patients to the way they are treated and communicated with, both medically and personally. That is how the physician's image is formed.

Just what is that image?

The American Medical Association provides us with important insights which reveal that our profession stands high in the public mind. Physicians rank first in public ratings of various professions for honesty and ethics, slightly ahead of engineers and college teachers and considerably ahead of journalists, lawyers, and legislators. Yet as high as physicians stand in relationship to others, there are warning signs that we must not ignore.

Forty-four percent of the public rates our

honesty and ethics as average or low with a large percentage of this forty-four percent coming from poor non-whites and families where income is less than \$3,000 per year. Concern for the poor and unfortunate should be features of our daily behavior.

Generally speaking though, the public expresses satisfaction with the care it receives. The American Medical Association polls, conducted by the Gallup organization and the Spencer/Roberts Market Opinion Research firm, show that a consistent 80 to 85 percent of all Americans are satisfied or well satisfied with their care. Asked about their last medical experience, 56 percent reported it was "good" and another 26 percent rated it "satisfactory" while only 18 percent said they had a "bad" experience.

The two greatest areas of public concern about our profession are cost and availability, with cost holding a three-to-one response ratio over availability. And while hospital costs receive the principal focus, consumers feel that physicians represent the single largest controlling factor in hospital costs.

Physicians also show tremendous concern about the cost of medical care. It is that concern for the everyday problems of individual patients over and above their personal illness or health problem which will keep our profession high in the point of view of the general public. We must make it a point each day to continue to do our part in what truly should be an ongoing commitment of our entire profession.

John J. Egan M.D.

Deaths

GORDON KEPPEL, M.D.

Suddenly, at the age of 63, Gordon Keppel, M.D., died on the 4th of February, 1978.

Director of the Student Health Center at the University of Delaware, from 1953 to 1974, he was responsible for many improvements in student health care.

He was a prisoner of war during World War II, having served in the US Army Ranger Battalion in Italy. Later he was awarded by King George VI the Order of the British Empire because of medical care he gave to British prisoners of war.

Survived by his wife, Margaret, he also is survived by two daughters, Barbara Bean of Hereford, Arizona, and Jane Keppel of Toppenish, Washington; four sons, John F. of Portland, Oregon, Charles B. of Wheeling, Illinois, and Arthur B. and Gordon Jr., of Newark, Delaware; two brothers, Charles T. of Montrose, New York and Frank of Cambridge, Massachusetts; and four grandchildren.

The Delaware Lung Association is accepting contributions in his memory.

CHARLES M. BANCROFT, M.D.



DANIEL J. PRESTON, M.D.

A general surgeon in Wilmington for 34 years,

retiring in 1974, Daniel J. Preston, M.D., died February 6, 1978.

Doctor Preston was a former President of the New Castle County Medical Society and of the Medical Society of Delaware. He had the status of Chief Surgeon during the period 1954 through 1970 at the Wilmington General Hospital and the Delaware Hospital. He also occupied a similar position at the St. Francis Hospital.

In 1934, he graduated from the Temple University School of Medicine, after having been an undergraduate student at Pennsylvania State College. He served his internship at Pennsylvania Hospital in Philadelphia, and was instructor in surgery at Temple University School of Medicine for three years.

Doctor Preston was a member of the US Army Medical Corps, serving in France during World War II.

He will be remembered for the introduction of a new stainless steel wire mesh implant technique in hernia repair. A member of many medical societies, he was a Fellow of the American College of Surgeons, a Fellow of the International College of Surgeons, and a member of the Southeast Surgical Congress and the Pan-Pacific Surgical Society.

He is survived by his wife, Amy B. Preston, and a brother, James, of Mansfield, Pennsylvania.

Contributions in his memory will be accepted by the American Cancer Society.

CHARLES M. BANCROFT, M.D.

DIFFERENTIAL DIAGNOSIS AND MANAGEMENT OF COMMON ARTHRITIDES

SHELDON D. SOLOMON, M.D.

The appropriate management of the various types of arthritis and rheumatism first requires an appropriate specific diagnosis. At present there are over a hundred types of disease causing the various manifestations of arthritis and rheumatism. Utilizing the basics learned in medical school, ie, interviews and appropriate physical examination along with a few laboratory tests, the clinician should be able to arrive at an appropriate diagnosis and start specific treatment. Table 1 lists the most common conditions presenting to a primary physician's office. These will be discussed in detail in the following paragraphs.

Non Articular Rheumatism

There are four types of non articular rheumatism: fibromyositis, polymyalgia rheumatica, polymyositis, and isolated episodes of bursitis or tendonitis.

These conditions can generally be differentiated by clinical evaluation and with the help of a few laboratory tests. In both polymyalgia rheumatica and fibromyositis, the patients complain of a great deal of muscular aching; typically the discomfort is not in the joints. In both of these conditions, if you can get patients to overcome their pain enough to examine them, they appear to have normal strength. An important differentiating factor is that in fibromyositis (a condition thought possibly due to tension) the Sedi-

mentation Rate is usually within normal limits for the patient's age and sex while in polymyalgia rheumatica it is markedly elevated. Patients with polymyositis usually complain more of weakness than pain. On objective testing they have definite muscle weakness, particularly in the proximal muscles of the neck, arms, and legs. This condition can usually be verified by elevated serum enzymes such as the CPK or SGOT, and finally by a muscle biopsy, which will reveal changes of necrosis, inflammation, and regeneration. Enzymes and muscle biopsies in fibromyositis and polymyalgia rheumatica are within normal limits.

Isolated instances of bursitis and tendonitis are usually easy to determine if the physician has a knowledge of the common sites such as the shoulder, hip, and knee where these conditions are seen.

Articular Rheumatism

In articular rheumatism the patient usually complains of localized joint pain involving either one or many joints. Here the most common conditions to be differentiated are osteoarthritis, rheumatoid arthritis, crystal deposition diseases including gout or pseudo-gout, and spondyloarthropathies. Once again the clinical examination, along with a few basic studies, is usually helpful in making the distinction. In the history important clues to the diagnosis of rheumatoid arthritis are morning stiffness of prolonged duration, usually an hour or longer, and moderately severe fatigue as the day wears on. The crystal

Dr. Solomon is Clinical Associate Professor of Medicine, Jefferson Medical College, Thomas Jefferson University, Philadelphia, Pennsylvania.

Adapted from a presentation for the Delaware Academy of Family Physicians Fall Course.

TABLE 1

CLASSIFICATION OF
ARTHRITIS AND RHEUMATISM

1. Non articular rheumatism
 - Fibromyositis
 - Polymyalgia rheumatica
 - Polymyositis and other collagen diseases
 - Localized soft tissue problems; ie, tendonitis, bursitis
2. Articular rheumatism
 - Osteoarthritis
 - Rheumatoid arthritis
 - Crystal deposition diseases
 1. Gout
 2. Pseudo-gout
 - Spondyloarthropathies

deposition diseases such as gout and pseudo-gout most commonly present with explosive joint swellings of an intermittent nature, the patient being almost asymptomatic between attacks. Osteoarthritis is a more chronic problem with low grade symptoms.

On physical examination, rheumatoid arthritis is usually a symmetrical disease involving both sides of the body while gout, pseudo-gout, and osteoarthritis are asymmetrical. Patients with spondyloarthropathies usually have complaints of an inflammatory nature, of both the spine and peripheral joints. The Sedimentation Rate can be very important in distinguishing osteoarthritis from the other diseases; it is usually normal in osteoarthritis but elevated in the other conditions. Synovial fluid analysis is the key in evaluating articular rheumatism. A few simple studies of synovial fluid easily obtained from the knee joint can help to pinpoint the correct diagnosis.

One must keep in mind that a few commonly ordered laboratory tests should be used *only* in the context of the clinical condition. For example: Rheumatoid factor is a very nonspecific test, which can often be positive in many conditions other than rheumatoid arthritis, and is negative in over one-third of patients with rheumatoid arthritis. Conditions that can give a false positive rheumatoid factor include the aging process, viral syndromes, other collagen diseases, sarcoidosis, and bacterial endocarditis, to name just a few.

DESCRIPTION Each tablet of PERCOCET®-5 contains 5mg oxycodone hydrochloride (WARNING: May be habit forming), 325mg acetaminophen (APAP).

INDICATIONS For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS Hypersensitivity to oxycodone or acetaminophen.

WARNINGS **Drug Dependence** Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of PERCOCET®-5, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, PERCOCET®-5 is subject to the Federal Controlled Substances Act.

Usage in ambulatory patients Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using PERCOCET®-5 should be cautioned accordingly.

Interaction with other central nervous system depressants Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with PERCOCET®-5 may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Usage in pregnancy Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, PERCOCET®-5 should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Usage in children PERCOCET®-5 should not be administered to children.

PRECAUTIONS **Head injury and increased intracranial pressure** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions The administration of PERCOCET®-5 or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special risk patients PERCOCET®-5 should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

ADVERSE REACTIONS The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include euphoria, dysphoria, constipation, skin rash and pruritus.

DOSAGE AND ADMINISTRATION Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. PERCOCET®-5 is given orally. The usual adult dose is one tablet every 6 hours as needed for pain.

DRUG INTERACTIONS The CNS depressant effects of PERCOCET®-5 may be additive with that of other CNS depressants. See WARNINGS.

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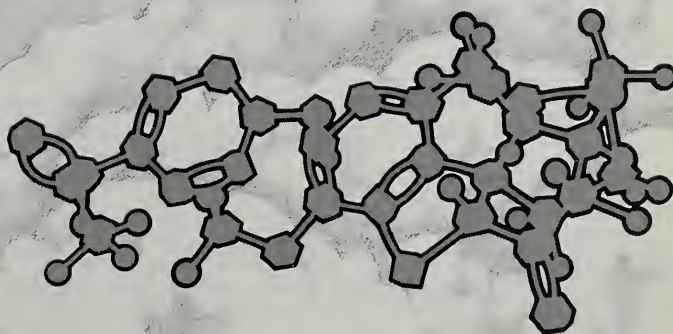
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Please see facing page for Brief Summary of prescribing information.

TABLE 2

DRUG THERAPY IN THE COMMON ARTHRITIDES

	RHEUMATOID ARTHRITIS	POLYMYALGIA RHEUMATICA	GOUT	SPONDYLOARTHROPATHY	OSTEOARTHRITIS
HIGH DOSE ASA	++	—	—	+	+
INDOMETHACIN	+	—	++	++	—
LOW DOSE PREDNISONE	+	++	—	—	—
PROPRIONIC ACID DERIVATIVES (eg, fenoprofen, ibuprofen, naproxen)	+	—	—	—	+
PHENYL BUTA- ZONE	—	—	+	+	—

— = NOT USEFUL
+ = USEFUL
++ = VERY USEFUL

Serum uric acid assessment is not a specific test for gout. Many people with hyperuricemia do not have true gout arthropathy, while at least 5% of gout patients have a normal serum uric acid. The only definitive way to diagnose gout is to see sodium urate crystals within the joint fluid or to get an excellent response to colchicine therapy.

Recent studies showing that HLA-B27, one of the major histo-compatibility antigens, is found in a high percentage of patients with spondyloarthropathies have been a major advance in our field. This antigen is seen in over 95% of patients with ankylosing spondylitis, 85% of patients with Reiter's syndrome, and a moderate percentage of patients with spondyloarthropathies of psoriasis and inflammatory bowel disease. The test has to be taken in the clinical context, however, since approximately 6% of the normal population may have the antigen present.

Once the physician has made the diagnosis, management is usually much easier. Table 2 lists the drugs which are useful in the most common diseases. In rheumatoid arthritis, the preferred medication is high dose salicylates. Good patient compliance can frequently be difficult to

obtain, but often the patient will cooperate and take the drug faithfully if the doctor expresses his sincere belief that aspirin is his drug of choice.

Anti-inflammatory levels are required; this usually means the patient must have anywhere from 12 to 16 tablets of aspirin per day. Newer drugs such as ibuprofen (*Motrin-Upjohn*), fenoprofen (*Nalfon-Dista*), naproxen (*Naprosyn-Syntex Puerto Rico*), and tolmetin (*Tolectin Tablets-McNeil*) are excellent substitutes if the patient has aspirin intolerance but are not given as first-line therapy because of their cost and possible side effects. If the patient does not respond to this basic program, combined with appropriate rest, local injections of long-acting steroids into the inflamed joints, and an exercise program, then secondary therapy such as gold, penicillamine, or chloroquine is initiated.

The results of therapy in gout are extremely gratifying. Therapy aimed at lowering the uric acid is initiated after the acute attack has been quieted by the use of indomethacin (*Indocin-Merck Sharp & Dohme*) or phenylbutazone. The drug of choice for lowering the uric acid is allopurinol (*Zyloprin-Burroughs Wellcome*). Probenecid (*Benemid-Merck Sharp & Dohme*) may

also be used in patients who are not over-excretors of uric acid. At present colchicine therapy is limited to the patient in whom a therapeutic test is required as to whether the patient does have gout. An excellent response would most likely indicate that the patient does have a gouty arthritis. A large percentage of patients are over-excretors of uric acid; hence one would not want to give a drug, such as probenecid, which would in likelihood lead to renal calculi.

The spondyloarthropathies, including ankylosing spondylitis, psoriatic arthritis, and Reiter's syndrome, seem to respond not as well as rheumatoid arthritis to aspirin therapy, but appear to respond well to either indomethacin or phenylbutazone. It is sometimes stated the response of patients to indomethacin is a good diagnostic test; ie, they have no response, they probably do not have ankylosing spondylitis.

Polymyalgia rheumatica is another disease which is gratifying to treat. It responds to moderate dose steroid administration for only a short period of time. One is then able to taper down to very small doses (between 5 and 8 mg/day) of

prednisone which maintain the patient almost asymptomatic and cause very few side effects.

Polymyositis and other collagen diseases can be more difficult to manage since their courses are so variable and often massive doses of steroid therapy as well as other immunosuppressive therapy are required. Patients with fibromyositis, although they have a good prognosis, are often resistant to the usual anti-inflammatory medications. When this occurs, careful consideration of other possible problems and particular attention to specific physical therapy routes are indicated.

In summary, in the management of the various rheumatic diseases, great stress is placed on making the appropriate diagnosis. This can usually be determined by coupling a careful physical examination with the laboratory data. Once the diagnosis is established, the appropriate mode of therapy can be instituted which often yields gratifying response.

No longer should a patient be told, "You have a little arthritis, learn to live with it."

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FAMILY MEDICINE: WHERE DO WE STAND AFTER FIVE YEARS?

ROSS L. EGGER, M.D.

What I would like to do is first of all to address the subject "Family Medicine: Where Do We Stand after Five Years?" and then spend a little time discussing one of my pet projects "What General Practice Has Given Family Medicine." In 1967 I was appointed to represent the mid-western region on the education commission of the American Academy of Family Physicians. The first project in which I was involved was filling out an application for specialty status for a new specialty, Family Practice. This included the development and approval of a document called "The Core Content of Family Medicine." When I think back in terms of that original group of board of directors and education commission members trying to do battle in an arena where we were both out-numbered and not privileged in advance to know the rules of the game, the television commercial, "You've come a long way, Baby," comes to my mind.

In those days, the input into the new specialty of Family Practice was specifically and entirely from those of us in general practice. We accepted the fact that we were not education experts, but felt that if there was a body of knowledge that was unique to general practice it should be incorporated into the new specialty called family practice. We began with what we felt was the basic core of knowledge necessary to practice good, quality general practice. To this we added some of what we considered the unique and outstanding functions of general practitioners, including counseling, preventive medicine, community medicine, sports medicine,

and a host of other things we felt could be taught in a residency program.

We had an interesting experience debating our philosophies with the other specialty board representatives, including the one part of the specialty application which seemed to cause the most controversy, our suggested requirement that recertification is a must to prove continued competence and to allow the candidate to compare his knowledge with other candidates on a regular basis with the hope that this comparison will allow him to remain current. We finally received official blessing to use these newly approved essentials for a family practice residency and to begin educating family physicians.

The Growth of the Residency Program

In 1969, there were many general practice residencies throughout the country, mostly two-year rotating experiences filled with foreign medical graduates. They had very little educational planning and most could not qualify as true family practice residencies. There were several outstanding general practice residencies in the country; these were used as a core to which were added about fifteen new programs which applied for approval of family practice residency programs in 1969.

From the beginning, I felt that if family practice was to grow and serve the needs of the patients in the United States, we had to involve community hospitals as well as medical centers. I like Lynn Carmichael's definition, made in '69, concerning the use of the terms family practice, family physician, and family medicine. Dr. Carmichael felt that the discipline called family medicine should be based in the university. The

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Adapted from a presentation to the Department of Family Practice, Wilmington Medical Center.

Family Medicine: Where Do We Stand after Five Years?—Egger

practice of family medicine should be called family practice and should be based in hospital and physician's office. Thus, the family physician is a physician in the practice of family medicine.

In 1969, there were 30 approved programs. A core of original residencies considered the best of the then present general practice residencies made up about half, and the other half were newly approved programs. All of the programs met the newly formed essentials, but those were interpreted loosely, and there was a considerable amount of variation between programs such as the one at Harvard and those at York, Pennsylvania, Muncie, Indiana, and Wichita, Kansas. In 1968 when we projected the next ten years in family practice, we felt that if things went well we should be able to have 100 family practice residencies within five years, ie, by 1973. Actually, there were 191 programs by that time. We projected that in ten years we would have 250 programs; we will probably reach 350 programs within ten years. The growth of family practice has thus far exceeded our expectations in those early days of planning. Originally, we felt that the average program would have 15 residents, and therefore 100 programs would give us 1500 residents and so on. Actually in the five-year period to 1974, there were 2600 residents; and this year we have 5000 family practice residents in training.

To continue the development of the discipline we knew it was necessary to develop undergraduate programs in medical schools to supply an academic and research base. In 1975, 66 schools, or about 55% of all US medical schools,

had family practice departments. In 1976, there were 79, or approximately 68%; 21 other schools had divisions of family practice. Only 12 schools still had divisions in 1976, showing that many of these divisions had been converted to departments. In 1978 112 American medical schools have some sort of undergraduate training program for family practice.

Of the 288 approved family practice residencies in '76, 164 (57%) were in community hospitals, 61 (21%) were university-based programs, 49 (17%) were university-affiliated programs, and there were 14 (5%) armed forces residency programs.

Family practice residencies are clustered around the East and Midwest, some states in the West having no residencies or very few and far between so there are still many locales where residencies can be developed. A survey of family practice residencies made in August 1976, showed a total of 4,675 residents in training; 1,861 first year; 1,577, second year; and 1,237, third year. For the 1,935 available total first year positions, there was an astonishing 96% fill rate. Since there were several programs in 1976 that were approved but not programmed to take their first resident for a year, the figures are even more astounding. Also, during the August 1976 survey, we found 407 foreign medical graduates in residency programs in family practice, and 16 Canadian medical graduates. There were 477 women and a total minority group membership of 360.

Where Do Family Practice Residents Practice?

Family practice training programs are fre-



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quently asked what happens to residents after they graduate. A survey in 1966 showed that more than a third of our residents have ended up in towns of less than 15,000; well over half of our residents have gone into communities of less than 30,000. There were actually 66 residents (16.3%) who chose to practice in communities of less than 5,000. That figure was virtually zero a few short years ago. Although this can be used to say that residents are more interested in small groups or larger small towns, it is also astonishing that in spite of the pressure from medical schools, from our own residents, and from practically all of the medical journals to scrap the idea of solo rural practice, we still have 16% of our residents electing small town, rural family practice.

Where we are going from here is another very common question. We have been more or less riding on the crest of popularity, with all the lay magazines and most of the medical students in support of us, and a lot of universities accepting us, perhaps reluctantly. What does the future really hold? A student interest survey using only United States graduates for the years 1974-76, showed that among medical students graduating in 1974, there were 1,854 interested in family practice but only 1,300 positions. By 1976, the number interested had increased to 2,483 with only 1,935 positions available. We estimate by 1980 there will be at least 4,000 positions available in first year, and we can only assume that, unless we do something to change it, medical student interest will continue to be greater than the number of positions available for graduates.

Problems

I would now like to turn to some of the present problems as I perceive them in family medicine. First, I have just shown that there has been a definite impact on medical students thus far, but I'm afraid that in many instances lay publications and family pressures have produced this interest in family medicine, and unless we develop a strong base, equal to the other specialties, in medical school, this interest will begin to decline. With state legislatures almost being forced to require departments of family medicine, medical schools have accepted us reluctantly in many

cases. We now have assignments to teach such things as community medicine, and there are other areas where we are exposed to undergraduate students, but the majority of our exposure still comes through the old time-tested preceptorship with all of its faults and the lack of predictability in what's going to occur during that experience.

We must now strive to receive clinical equality in medical schools so students can actually see what family physicians do and do best, and so they can also see family medicine academicians functioning side by side and holding their own with other specialties. These functions would include such things as physical diagnosis and also the specific disease-oriented portion of curriculum to be taught by family medicine academicians side by side with the other medical specialists. This just hasn't yet occurred to any large degree.

A second problem I see is that family practice residencies have not been concerned enough about the local and regional needs of their graduates. Residencies have got to become more involved in local and regional needs and to adapt their curriculum to produce the kind of physicians needed in their area.

A third problem I see at the present time is that there needs to be better rapport developed between family practice and other residencies. If family physicians and other specialists are going to function side by side, they need to grow up and learn medicine side by side; that means we have got to define very specifically the responsibility for patient care in a hospital in order to minimize jealousy and bickering between residents. That also means family practice residency directors must confer with the directors of the residency programs to be certain that our residents are utilized in ways fitting for family practice so that all can develop a reasonable understanding of what each specialty has to offer in the training period. A fourth problem, still lurking on the horizon in many cases but more obvious in some, is that of hospital privileges. These are local battles, and I see no way that a national organization can do more than offer guidelines. It behooves all family practice programs to keep very careful documentation of all

patient care experiences during the residency so that the resident can use this to show training and experience when he applies for specific privileges in a hospital.

Family practice residencies must accept their role as centers for family practice education much more than they have done in the past. In most instances this means that the state Academies of Family Physicians and state medical schools must try to provide as much education for local family physicians as possible, partially by involving family practice residencies throughout the state. Another problem I see, although it is perhaps not as large a problem as others see it, is that of the other primary care specialties. Because we are defined as family physicians and our discipline is family medicine, the word family needs to be emphasized continuously. If other specialists want to practice medicine or pediatrics, I have no qualms about it, and I see it causing no harm to family physicians. There are

many patients who desire a segregated relationship with a physician. But there are a large number of patients who would like to have a single physician who is responsible for the health needs of their families; we must continue to emphasize the role of the family in family practice.

Another problem is that successful residencies may get lulled into thinking they are doing well and do not need to take evaluation seriously. Residencies need to be much more involved in critiquing themselves and accepting outside critiques from medical societies and hospital staffs and even from other physicians practicing with or in the same locality as their family practice graduates. We must be willing to take these criticisms and use them to improve our curriculum.

In family practice education we frequently try to compete with other specialties in our training programs. This is directly fostered by the residency review committee, but is indirectly

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fostered because this is the way we ourselves learned. It seems to me that we are still spending far too much time in our residency curriculum learning about disease and its management and not enough time learning about managing the health of a family. Simply providing education to allow residents to enter an examination room and talk with a patient, diagnose an illness, and prescribe therapy is only one-tenth of what a family physician does; we need to spend more time in our curriculum on the other 90% if he is to be able effectively to address the health needs of the family beyond diagnosis and therapy of organic disease.

Finally, there is a problem we all knew was going to happen, but perhaps of which we need to be reminded: the pump is going to go dry some day. The ability of family practice programs to receive monies from federal, local, and state agencies and institutions is eventually going to stop. We all need to be very careful to establish a sound financial base in our parent institutions which will allow our residency programs to succeed with or without outside aid. We should also assume that the pump will be going dry with respect to student interest, and, therefore, we have to make a continuing impact on undergraduate medical student curriculum.

What Is the Future?

I would like now to discuss the future of family practice as I see it. I feel the future looks extremely good, much better than most of us expected, not only with respect to total numbers, but also in that we actually are almost daily accomplishing the impossible in family practice. We have been able to bridge the gap effectively between the "good ole G.P." and the highly skilled trained family physician. We have been able to use the short cuts, the office efficiency tools, the family dynamics information, and many other things that made the "ole G.P." an outstanding friend and physician. We have been able to teach attitudes and skills we thought couldn't be taught. We are actually able to teach a resident how to be concerned, how to ask the relevant questions, and not simply to do a complete data inventory every time a patient comes in. We are actually able to teach a resident how to educate his patient so that he understands the illness for

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which he is being treated. Therefore, we are able to do that one thing that no other specialty does, the thing that made the "ole G.P." so outstanding: we are able to involve our patients in their own illnesses, making them in part responsible for the outcome, and at the same time we are able to be considered our patients' friend and not just an adult or computer-type model, to use the terms of transactional analysis. In the future I believe we will see a gradual decline in student interest in family practice and at the same time a gradual decline in the funding sources. I don't think this is necessarily all bad. It does mean we are going to be forced to compete more vigorously with other specialties for quality residents.

Another thing the future holds will be a decline in the number of new programs being approved. Less than one of three programs which have applied have achieved final approval. We are now going to find a decrease in the total number of new programs applying because the requirement that there be a sound financial base will become more important than having a family

practice residency on board simply to replace the old housestaff cadre used by so many hospitals for so many years. For many hospitals it will just not be financially feasible.

In addition, many of the family practice programs now active will not be present five years from now. These programs will fold because of lack of financial support from their parent institution, lack of moral and educational support from their hospital staff, and lack of true commitment from the community for this type of residency.

In the near future I believe we are going to see a lot of specialty programs in trouble. As the sub-specialties such as cardiology, nephrology, hematology, and others have to justify the length of their training periods to the federal government, I feel that they will be required to cut their total training period and also to practice only in their specialty area so we will see fewer overtrained physicians practicing very minor specialties. But also, because of the specter of recertification, we are going to find a more highly defined list of objectives for each of these minor specialties and find that interest in them will decrease immensely in the near future.

I would like to discuss one of my pet peeves, the apparent demise of the solo physician. If we look at medical education today, we find students are being taught by the largest group practices in the world, the medical schools. It is a situation where not only is no one physician responsible for the total care of a patient, but also the teaching physician's income is not predicated on his ability to please a patient. As a result, four years of medical education convince a medical student that he can not practice alone. This produces an interesting phenomenon in residents first starting residency; we continually have to convince the resident that he can himself do a good job and doesn't need help. In our own program we have found that of twelve graduates, we have seven who are practicing solo. Of these, five are in small communities, so apparently having a role model, such as I am, has had some impact on what type of practice our residents choose. We are in the process now of developing a specific curriculum that we feel will equip a resident to manage a solo rural

practice if he so desires. We are doing it not to convince our residents that this is the way they should practice but simply to make experience with solo medicine, which is still the most frequent form of medical practice, an alternative for our graduates.

What has actually happened is that for years large funding agencies have tried to fit a large city-type practice or group, or physician extender-type practice into small rural communities. Small rural communities just don't buy this kind of practice for many reasons, one reason being that to live in small rural communities automatically means that the patients are much more independent, and more willing to assume a lot of responsibility for their health care than are large city-patients who have been brought up to use the emergency room for 24-hour-a-day coverage, seven days a week. Group practices just don't fit into small rural communities; they cannot be supported financially or philosophically.

Since we have ended up producing graduating physicians who don't even consider rural solo practice as a viable alternative, we have ignored the needs of thousands of small rural communities. We must now provide ways for physicians to develop emergency medical services in their communities, ways to make patients more self-sufficient so they do not need to bother the physician at all times, mechanisms for handling those rare true emergencies that occur perhaps once a month, and ways of utilizing other people than the physician to take calls, such as his office nurse, (After all she probably now handles as many patients on the phone every day as physicians do; it simply isn't realized or is ignored.).

In summary, the family practice movement has far exceeded our expectations and continues to be viable. I look forward to nothing but great things occurring in the future of family medicine, provided we are willing to accept the fact that our present popularity may not last much longer, provided we can prove to medical students that we are a viable specialty, and provided we continue to assess ourselves to insure that, as much as possible, we are offering the kinds of curricula that are necessary to provide the kind of physicians that our public expects.

Letters to the Editor

To the Editor:

In the article printed in the July, 1975 issue of the *Delaware Medical Journal*, Vol. 47, No. 7, entitled, "A New Concept for the Treatment of Hyperpathia after Trauma," in Case II, the date of the initial surgery was December 24, 1973, not October of 1973. The early good result of the silastic intrapositioning procedure was not sustained; the symptoms recurred. From the time that the article was submitted for publication in August of 1974 and its publication in July of 1975, this patient required four more surgical procedures.

JOSEPH A. ARMINIO, M.D.



To the Editor:

The need to understand the complex dynamics facing a victim of rape is perhaps greater than for victims of other violent crimes because of the mixed messages and myths perpetuated by our society regarding rape. FBI statistics report that the number of reported rapes has increased 165% over the last 15 years. This figure may be a result of more rapes actually occurring or may be indicative of more women reporting it. Whichever the reason, this increase necessitates a growing demand for knowledge, sensitivity, and competence on the part of interested practitioners in dealing with the complex and varied emotions of the rape victim.

Psychological trauma may affect a woman's interpersonal relations, physiological patterns (eg, sleeping, eating, self-concept, and overall functioning) for many months, sometimes years, sur-

facing in overt ways such as fear of all males, an inability to be sexually active with men and marked restriction of freedom of movement and life style and a heightened vulnerability as she attends to daily activities.

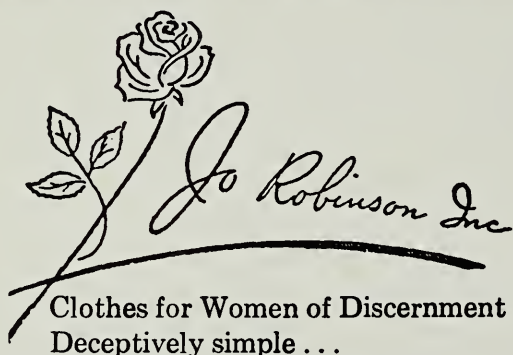
Rape Crisis Hot Lines like the one in Delaware provide support and legal and medical information and help the troubled victim cope with the experience at hand.

There are basically three goals in counseling a rape victim. First, the counselor must establish a working relationship with the rape victim, by being supportive and conveying trust and understanding rather than disbelief, anger, accusations, and judgmental statements. The second area of focus is the provision of practical information. "What will happen if I report the rape?" "Will my parents have to know?" "If I go to the hospital will they automatically report it to the police?" Helping her to make these decisions is important to assist her in subsequently regaining the feeling of having some control over her life.

A final but very crucial area in meeting the needs of the rape victim has to be legal change. Briefly, areas that demand special legislative attention are 1) strengthening the sentence for rape, 2) including men as possible rape victims, and 3) improving rehabilitation for penalized rapists. The importance of providing competent help for rapists is accentuated by the fact that in more than 50%, the rate of recidivism is very high. The need to uncover the underlying hostility is of prime significance, and only in a therapeutic setting can this be possible since rape is an act of aggression rather than sexual gratification.

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To the Editor:

I would like to make comment pertaining to Dr. Joel R. Temple's letter, in the December, 1977 issue, page 697.

Many of us who have been involved in the care of patients for many years, are well aware of the fact that all answers are not in for all questions. Most certainly, all answers are not in for the sticky wicket of abortion.

Each side has what it believes to be the true facts. But really, it just is not so.

For example, any physician who has been involved with patients, even a few years, can select at random from his practice, parents who are quite upset because the wife is pregnant, and yet when the child is delivered, the infancy, and the later years give the family more happiness than they ever dreamed of. How many mothers rid themselves of their cerebral palsied child?

Some day the problem is going to be settled as to just when cutting the umbilical cord is or is not purposeful destruction of life.

Aggressive statements pertaining to abortion are bound to offend sensitive members of our Society, whether they are pro-life or anti-life, whether they are Roman Catholic, Protestant, Jew, or Moslem.

What is pregnancy?

Some believe pregnancy is a *soul*, inside a *fetus*, inside a *uterus*, inside a *peritoneal* cavity, inside a *woman*, inside a *mother*.

Others believe pregnancy is *fetus-uterus-peritoneal cavity-woman*.

Soul-mother. Is that the basic conflict?

In conclusion, I still feel that it is *soul-fetus-uterus-peritoneal cavity-woman-mother* vs. the other group who drops *soul* and *mother*.

Both Dr. Paulshock and Dr. Temple are physicians with competency. They have earned our esteem. Neither one is a "fuzzy thinker."

CHARLES M. BANCROFT, M.D.

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PROTECTION FROM EMBEZZLEMENT

LEIF C. BECK, LL.B., C.P.B.C.
VASILIOS J. KALOGREDIS, J.D.

It is rare that physicians seriously suspect that one or more of their employees might be dishonest. In spite of this, embezzlements do occur in medical offices.

Since doctors are generally preoccupied with patient care matters and since they therefore often tend to ignore good accounting control principles, physicians' offices are prime targets for nearly undiscoverable theft by employees.

This article will explore some of the areas of exposure, the symptoms, and some thoughts regarding prevention of theft and embezzlement in medical offices.

Application of these principles can help to diminish the likelihood of such losses, although there is no absolutely foolproof approach.

A. Exposures

There are various areas of theft and embezzlement exposure in a medical practice.

1. Undoubtedly the most obvious is the pilfering of patients' cash payments. In a "loose" system, it does not take much imagination to envision how a receptionist or other employee handling cash could embezzle such funds with little difficulty.

A sound cash control system is required in a practice. The section on prevention will set forth some examples.

2. Check are another potential source of embezzlement difficulties. There are various potential problem areas.

One is for an employee to have the physician sign a blank check "to save time." Once a blank check has been properly signed, it does not take much for the employee to fill in her own or a

friend's name and have the check very easily cashed.

Also, checks made to "Cash" are easily negotiable and should be avoided if at all possible. Such checks make it difficult to trace the payee.

Another area of difficulty is the forged endorsement of a check by an unauthorized employee. This calls for close review of the checks.

Practices should watch for the situation where there may have been an insurance overpayment (usually because a patient might have paid more than his or her share of a bill). In those instances, there is some risk that an employee might "take" the difference over and above the amount owed to a doctor. There would be no suspicion on the part of the patient since the patient would no longer be receiving bills. The doctor's office might not become aware of this since it had been fully paid and therefore a zero balance would show on the bill.

3. Petty cash can sometimes result in a theft problem that is not so "petty." Offices sometimes have upwards of \$50 available in petty cash. A programmed and regular embezzling from this account by a determined and secretive employee can cause problems. In light of that, it is most important that there be a review and audit of petty cash periodically by someone other than the individuals who handle it on a regular basis.

4. Money is not the only thing that can be stolen from a medical practice. Drugs, supplies, and other office materials can be easily taken from an office. Particularly if the doctor or doctors are not often in the office at closing time, it would be very easy for someone to be taking supplies from the practice.

Messrs. Beck and Kalogredis are the principal consultants of Management Consulting for Professionals, Inc, Bala Cynwyd, Pa.

This is a good reason to make someone responsible for the ordering of drugs and other supplies and also to have an independent party (preferably a doctor or office manager depending on the circumstances) review the records from time to time in order to let the staff know that someone is looking at things critically and also to uncover any problems that might arise.

5. There have been instances where an employee in a medical office has conspired with someone outside of the practice. This "third party conspiracy" could take various forms.

One would involve an office employee "in cahoots" with a salesman. The salesman would charge the practice much more than is reasonable for a specific item, with the two of them splitting the profits.

Practices should watch for the salesman who bills the practice for something that was never received, with the conspiring employee and the salesman then splitting the funds.

Here again, it is most important to have someone overseeing the supply and drug ordering in order to provide the opportunity for picking up any major discrepancies.

6. The last exposure area we shall discuss involves an overstated payroll. In the smaller medical practice, there would be great difficulty in having "phantom employees." This would be more common in a larger employer situation (such as municipalities, possibly hospitals, and the like).

Although the above is not as likely in most

medical practice situations, there is always the possibility that, unbeknownst to the doctors, the bookkeeper might be adding a few dollars to her or others' pay which could easily slip by the employer unless the personnel records are periodically checked to the agreed-to salary or hourly wage.

This is a possibility that must be considered and defended against.

B. Symptoms

There are various things that can sound an alarm and cause a physician, office manager, or advisor to dig more deeply into the situation.

1. The first would be a declining collection ratio (receipts divided by charges). If there is not another logical explanation for the decline, there should be real concern as to whether there is an embezzlement problem. For example, if work has continued to be steady or perhaps growing at a conservative rate, a sharp drop-off in collection experience would be a real tip-off that there might be a problem.

2. If there is an unexplained and unusual cash flow problem in a practice, this also should cause concern and a critical review of the handling of cash in the practice.

3. Unexplained accounts receivable trends in a practice can also be a tip-off.

For example, if the accounts receivable are dramatically increasing while productivity is relatively flat, one must begin to wonder why the collections have not kept up the pace. One reason could be an embezzlement which has re-



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sulted in accounts receivable increasing as production increases without a corresponding increase in collections.

4. Dramatic increases in drug and other supply costs without any other reasonable explanation might also be an alarm.

This might be evidence of thefts of drugs and other supplies in the practice.

5. This next "symptom" surprises many physicians.

No one should simply assume or directly suspect an employee of dishonesty without reason; however, an overly conscientious assistant may be the prime candidate for an embezzlement.

For example, if a bookkeeper maintains unduly long working hours, never taking time off for illness or vacation, and keeping all financial responsibilities to herself, she may be covering up an embezzlement. In simple language, she may be trying to keep everyone else away from the books.

Such an individual would characteristically resist anyone else's review of her work, since she would fear discovery.

The long hard hours of work over the years might, in the assistant's own mind, have given her the justification that she is really "entitled" to the money she is taking, especially since she has "helped the doctor make so much money."

Of course, most assistants fitting such work patterns are in reality honest and loyal. It is an element to consider, however, in evaluating a potential embezzlement situation.

A management consultant friend of ours tells the story of a bookkeeper (let's call her Joan) who had worked in a doctor's office for 15 years. She was a hard working employee who was deemed "indispensable." The only other employee in the practice was a part-time student (let's call her Jane) who worked during vacations and on afternoons.

One day Joan became very seriously ill and was out sick for two days (the first time ever). Jane, who had been trained by Joan, handled the day's activities. At the end of the first day,

she came up to one of the doctors and said, "What should I do with the cash?" The doctor responded, "What is done with it every day?" Jane answered, "We never deposit cash, only checks." Joan had been taking the cash for herself, but no one knew it since no one had really ever looked.

6. Employees showing unusual emotional stress or experiencing personal financial difficulties are other potential candidates. For example, if an assistant's husband might have lost his job, there may be strong pressures on her for additional funds. A doctor's office generating higher income in part because of that employee's help (even though she has not rendered medical care) may cause such an employee to feel self-justified in an embezzlement.

Here again, in most situations this would not hold true, but it has proven true in some circumstances.

Although it may seem extreme, another real symptom would be a dramatic increase in an employee's standard of living. There have been circumstances where a \$10,000 a year assistant all of a sudden shows up at work one day with a \$10,000 automobile.

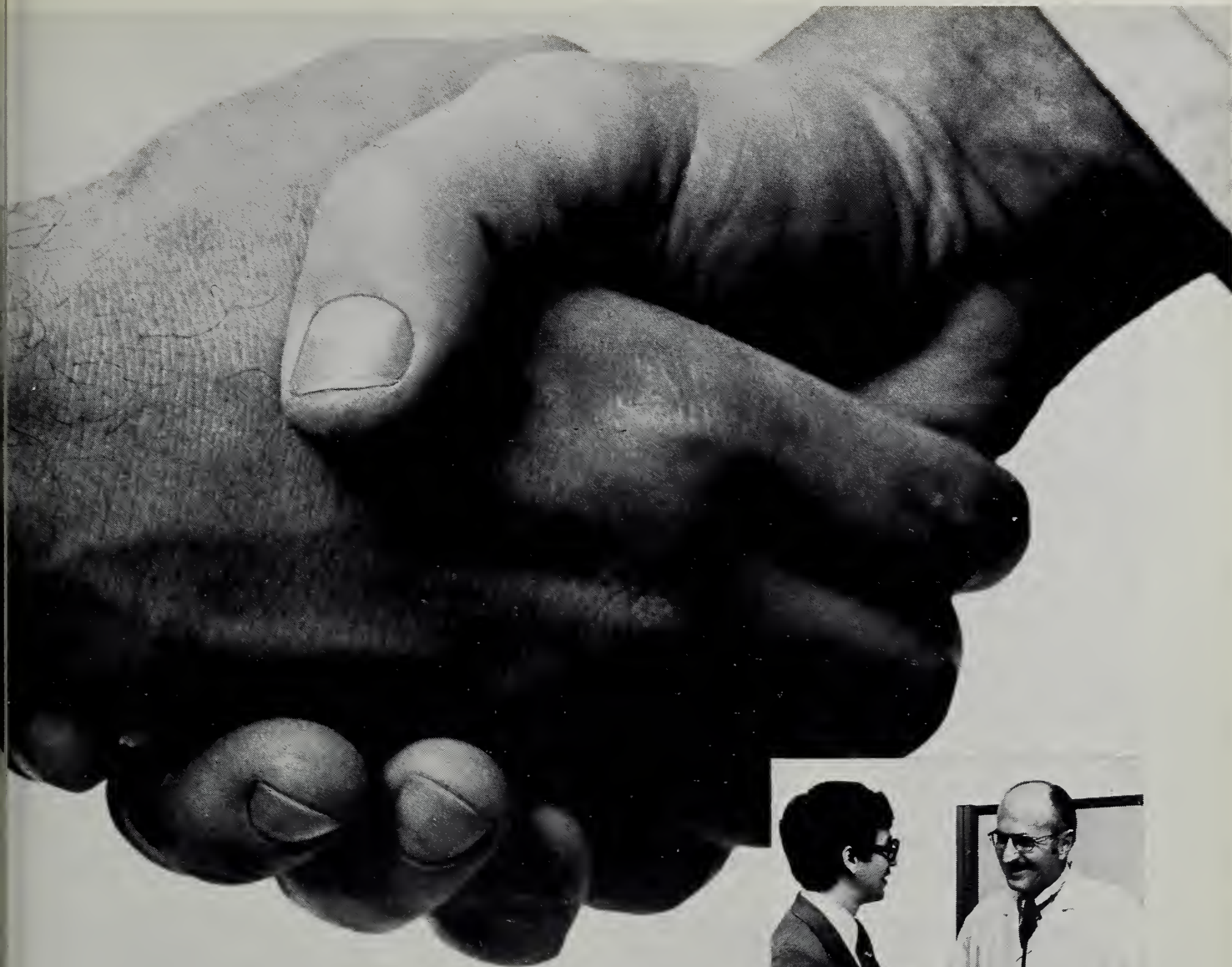
Unfortunately, it has happened.

7. Constant discrepancies in accounting can signal a problem. Constant difficulties in balancing the checkbook, tallying the "day sheet" so that deposits equal cash and checks, and the like can be real warning signs.

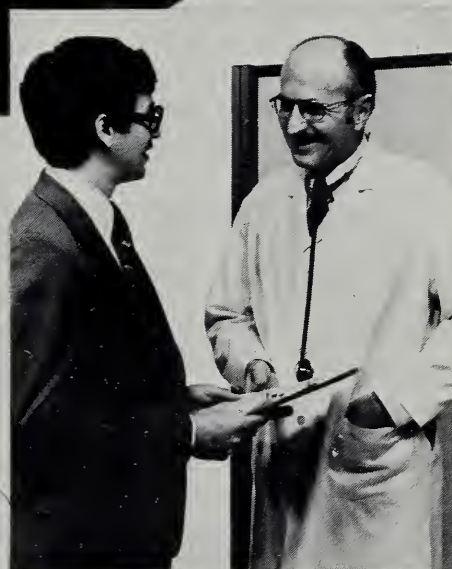
At the other extreme is a situation where there may never be accounting discrepancies because of a very sly individual handling the books.

Both of these are things that should be looked for in the "audits" that will be described in the prevention section of this article.

8. A final symptom is a progressively disrespectful attitude on the part of an employee. She may begin to feel that she is so smart and that she has so well hidden her tracks and taken advantage of the practice that it may begin to show in her attitude towards work and towards the doctors themselves.



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C. Preventive Measures

As we described at the beginning of this article, there is no foolproof system which can guarantee any employer that his practice is embezzlement-free.

Conscientious application of the principles to be enunciated below, however, go a long way towards achieving the goal of preventing theft and embezzlement.

A practice's application of these principles makes it more difficult for someone to steal.

1. A practice should hire well. Any medical office should desire and seek good employees. If one has done a good job in hiring, the theft/embezzlement exposure should be diminished.

This does require a conscientious follow-up on references and an interview process that will be as thorough as possible in making a good choice.

2. Once a practice has hired good and qualified employees, it is then important to cultivate loyalty among them regarding the practice.

We often see practices that are very similar in the volume of work, specialty, number of doctors, and even location; however, there are often large differences in the feeling of loyalty by the staff towards the employers.

If one can embody this feeling of "teamwork" and loyalty among the staff, the risk of a theft/embezzlement is once again diminished.

3. All employees who are in any way involved with the handling of funds (incoming or outgoing) should be bonded. One of the key questions we ask on an Employment Application is whether the prospective employee would refuse to be bonded. If an individual refuses to be bonded, we would refuse to hire her. Such a refusal probably indicates a past bad experience that would be on record with the bonding companies.

Also, during the reference check of previous employers, we recommend that a question be raised as to whether that employee had been bonded at the previous job. This can also lead into a discussion of whether this employee handled cash or other valuables and whether the

previous employer feels that she did a good job in those areas.

4. Another preventive measure is to keep a regular control of accounts receivable. We are amazed at how many practices have no idea what their outstanding accounts receivable are at any given period of time.

We recommend that a system be established in any medical office by which the accounts receivable can be computed on a regular basis. Many of the pegboard and other systems have this built into their processes.

Whether a practice has one of those systems or not, it is easy to keep track of receivables on a regular basis. Once a sound beginning figure has been established for accounts receivable, at the end of every month the charges for that month can be added to that figure, any receipts can be subtracted from that figure, and any write-offs can also be subtracted from that figure to come up with a realistic accounts receivable number. This is a helpful first step.

As a checking mechanism, at least twice a year (and preferably monthly) a tape should be run of all outstanding accounts. Although this tape will often not exactly equal the accounts receivable figure being kept on a regular basis because of mathematical or other errors, it should come very close to the correct figure. If it does not, this is a telling sign that an embezzlement problem may be present. This is particularly true if the tallying of the accounts receivable cards shows a much smaller figure than the running total does.

Besides being an excellent embezzlement control review, it also helps prevent the losing of charges and cards. Practices that have run things this way have sometimes found that cards were lost in drawers, put in the zero balance files, or even in someone's office or home. If the "accounts receivable balancing" had not been run, these funds would have been lost forever.

5. The increased emphasis on "collection at the source" in medical practices does increase the amount of cash available for theft. Therefore, there is an increased need to assure that a system for recording office charges and collections be as foolproof as is possible.

One of the outstanding features of a pegboard billing system is embezzlement control. Each office visit patient would be handed a slip showing the charges incurred and the payments received that day. The receptionist's recording of this information would be duplicated simultaneously on a day sheet and the patient's ledger card under the write-it-once approach. The likelihood of handing a patient a slip not reciting a payment just received would be minimal. Any alteration of the carbon entries on the day sheet or ledger card would also be apparent.

Computer and posting machine billing systems can also have similar safeguards built into them. A common approach is to have a two- or three-part fee slip upon which the entries would carbon through to the other copies. The top copy would be handed to the patient as a receipt, therefore involving the patient in the control system.

The day sheets should be totaled each day and reconciled with the cash and checks received during the day. In many cases the receptionist should be expected to handle this closing out process each day, therefore making her accountable for her work. However, the bookkeeper or office manager receiving the materials should critically review the books and deposit the receipts.

6. Another preventive measure requires outside, periodic surveillance of the books and records. This should be performed by the practice's accountant or medical management consultant.

This would not require a full scale audit of a medical practice's books. Letting one's staff know, however, that an "outside expert" will be reviewing the books periodically on an unannounced basis should prove to be a good preventive measure in and of itself.

This is an area in which many medical practices' accountants have been deficient. Some feel that if they attempt an audit and there is a subsequently discovered embezzlement, they will be more liable than if they did no checking. We disagree with this logic. No accountant can be expected to develop and guarantee an em-



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bezzlement-proof system. We believe he should take sincere steps, however, to cut down the probability in a practice.

7. No matter what system might be established and how good one's outside advisors might be, oftentimes the most effective audit control is the doctor's own attention. This might involve only an occasional few minutes of doctor time in informal and irregular audits.

On no particular schedule, a doctor should check isolated portions of his assistant's work. This might be coordinated through the accountant or medical management consultant so that some guidelines can be established.

For example, the doctor might ask the receptionist if he can check each name on an appointment book for a specific date to the same names on that particular day's summary sheet as well as to entries to those particular patients' ledger cards.

This testing should follow no pattern as to time or matters to be reviewed. The activity's major value is more as a deterrent than as a discovery device. An assistant who knows that her efforts to steal might be caught by this random process will be hard put to create a pattern on which she can rely. For this reason, this "audit" should be performed visibly with the employees involved present. It should be explained to them that it is being done for the doctor's and the assistant's protection at the accountant's or consultant's recommendation.

8. Except for those practices of clinic size, a physician should sign every check. This helps to discourage and keep a bookkeeper from writing unauthorized checks. In addition, it has the advantage of keeping the doctor informed as to where money is being expended.

The bookkeeper should be required to fill out each check completely, attaching the bill or invoice and putting them in a special file for the doctor's signature. It is important that incomplete checks never be signed (such as a blank check) and that one be very critical of checks made out to cash or checks made out to suppliers or individuals without an invoice, with incomplete invoices, or with a confusing invoice.

Here again, the fact that the bookkeeper knows that the doctor is signing the checks and will be reviewing the invoices can help serve as a deterrent.

The special file might be an unusually colored plastic folder so that the doctor will readily recognize it, to know the checks can be promptly signed. The doctor can sign a batch of checks in a few spare minutes while at the same time having an opportunity to look at each invoice to see where the money is going. This process will make the doctor aware of expenditures and should cause him to ask questions about anything that may not seem just right to him.

In group practices, we feel any one of the doctor's signatures should be sufficient for routine expenditures. A policy by which each specific doctor is primarily responsible for signing checks for alternating periods of time (perhaps three months) is desirable. It helps prevent the bookkeeper from avoiding inquiry by spreading similar checks among signers, and gives each doctor a better feel for expense levels of the practice as a whole.

9. Lastly, any employer should avoid the possibility of being exposed to extortion.

The two most common situations in which this can arise deal with tax problems (such as tax evasion) and personal relations (such as a physician being involved, extramaritally, with the bookkeeper).

These two points may seem too obvious to mention. They have come back to haunt various physicians in the past, however, and should be avoided. In cases where it has arisen, the doctor has been powerless to act against a known embezzler in light of the circumstances.

We recognize that the potential for theft or embezzlement in a medical practice can be present in a surprisingly large number of practices. As we mentioned previously, no one can establish a system that is 100% embezzlement proof. Recognizing the exposures and the symptoms and applying some of the preventive measures, however, will go a long way towards helping to avoid the problem in one's medical practice.

Editorials

THE MEGAVITAMIN REVOLUTION: AN OVERVIEW

Because of my long interest in nutrition, I have been following the ups and downs of various fad diets. Presenting we are in a period of enthusiasm for "megavitamin" therapy as described in *Supernutrition—Megavitamin Revolution*.*

Richard A. Passwater's book *Supernutrition—Megavitamin Revolution* is fascinating reading if outrageous. Passwater intimates that perhaps the AMA and the American Heart Association are in cahoots with the food industry in developing and selling polyunsaturated fat-containing foods. By the same reasoning the reader might wonder if the author might not be accused of promoting the wide sale of massive amounts of vitamins for commercial interests. The probabilities are that neither is the case.

The author claims expertise in many facets of medicine, perhaps because he is not an M.D. and has no personal responsibility regarding individuals. It is unfortunate, however, that this book was published because of its many unfounded statements and "pie in the sky" insinuations. There is wide review of the literature covering many aspects of nutrition; yet much of the evidence quoted to support the theory of supernutrition is anecdotal. Several US Senators are quoted though it is not clear how these Senators acquired authoritative knowledge of the intricacies of nutrition.

Several references are given in this review which the author has deliberately or accidentally overlooked, which is regrettable since the experimental *in vitro* and animal investigations regarding vitamin E, selenium, and vitamin C are interesting.

Exploration of the free radical theory as a possible basis for the aging process has been

discussed by Pryor, who concluded that the evidence for the beneficial role of Vitamin E is very weak and questionable.¹ In 1968 Tappel very clearly elaborated upon the antioxidant, free radical, and peroxidase aspects of the aging process. He pointed out the importance of polyunsaturated fats in diet and suggested that vitamin E, selenium, and vitamin C should be consumed in optimum amounts,² but how much is optimum remains to be determined by future studies. It is probably greater than many people consume at present, but not the high dosage recommended by Passwater. Tappel reported further, more detailed studies in 1974, still without being able to determine the optimum amount of these dietary substances.³

In December, 1974, Packer and Smith suggested from their investigations that antioxidants inhibit the accumulation of lipofuscin (age pigment), but that there still is no convincing evidence that free radical-mediated reactions are important in aging processes of human cells.⁴ Other studies by Witting indicate that the interrelationship of vitamin E and polyunsaturated fats is real, but complex.⁵ Increasing the tocopherol concentration beyond the optimal level does not further decrease the yield of peroxide and free radicals, and the dosage for humans has not been ascertained.

Supernutrition castigates the low-cholesterol, high-polyunsaturated diet advocated by many for prevention of coronary thrombosis and atherosclerosis. While it is true that many individuals with coronary thrombosis do not have high serum cholesterol and many with high cholesterol may not develop evidence of atherosclerosis, there is statistical association between cholesterol levels and coronary artery disease. It is also presumed that the atherosclerotic process gradually develops over a long period, and marked improvement by proper diet, even if that could be de-

*Richard A. Passwater: *Supernutrition—Megavitamin Revolution*. New York, The Dial Press, 1975.

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terminated, would not be expected to occur rapidly; diets with increased polyunsaturated fatty acid (PUFA) and decreased cholesterol have not been followed by many for very long. In this connection, it is interesting to note that in 1969, Kingsbury et al in London found that even without change in serum cholesterol or blood sugar, there was a far higher instance of vascular deaths when dienoic acid (PUFA) content was low.⁶

Passwater rightly points out that high intake of refined sugars may be an important factor in aggravating atherosclerosis. He also agrees with most nutritionists that high caloric intake is probably deleterious. Most investigators and nutritionists also agree that high intake of PUFA requires more vitamins, including vitamin E. Since there is some loss of vitamin E in processed foods with their added preservatives, the recommended daily allowance (RDA) may actually be too low. Still the astronomical doses recommended in this book seem to be out of line since these high dose recommendations are based on short-term animal experimentation which has been extrapolated into suggestions for long-term use by humans. There is no evidence of appreciable harm being done by ingestion of large doses of vitamin E, except for the expense incurred although recently there have been not-well-confirmed reports that such large doses of vitamin E cause mental depression in some patients. Horwitt, among others, agrees that vitamin E deficiency does occur in sprue, cystic fibrosis, and malabsorption syndrome, and in premature infants on a high PUFA diet as described in the present book under review.⁷ But Horwitt also concludes that vitamin E's importance as an antioxidant and free radical scavenger in retarding the aging process, although an interesting conjecture, so far has not been supported by concrete evidence. A review of vitamin E in the *Medical Letter* August 15, 1975 concludes that there is no convincing evidence that large doses of vitamin E are effective in prevention or treatment of heart disease or atherosclerosis.⁸

The question of the value of large doses of ascorbic acid has received great attention. Linus Pauling in 1974 continued his recommendations for large doses in prevention and treatment of

acute infections.⁹ On the other hand, a review of recent literature¹⁰ including several double blind studies (aside from the often-quoted and not very convincing double blind study of the Anderson group in Canada in 1973¹¹) concludes that large doses of vitamin C do not prevent colds or reduce their severity. The work of Hume et al indicates that the injured myocardium is flooded with ascorbic acid-laden leucocytes. Ascorbic acid is found concentrated in significantly large amounts at the site of the coronary occlusion. There is associated temporary decrease of plasma ascorbic acid levels.¹² This does not necessarily mean that the patient is deficient in vitamin C, but perhaps that the vitamin C is diverted to sites where it is needed.

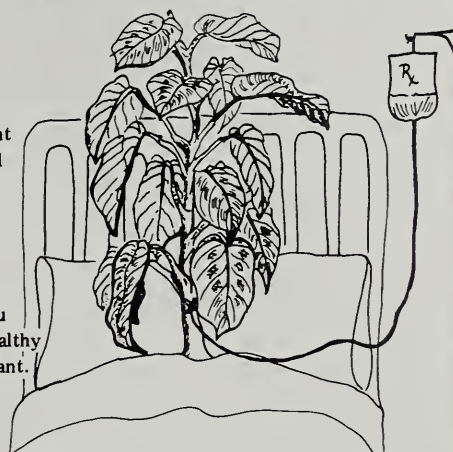
The enthusiastic presentation of megavitamin therapy in mental disease, if not bizarre, is at least experimental and should be carefully evaluated, not widely recommended at this time. Three to 30 grams of niacin per day; one to two grams of vitamin B₁; 100-500 mg of pyridoxine (B₆); three to 20 grams of vitamin C; 500-800 mg of alpha-tocopherol—these are fantastic dosages! Perhaps some of the therapeutic successes reported can be explained by the psychological impact of such “megavitamin” therapy.

At the end of Passwater's book a curious self-evaluation and score card is presented by which each person can determine his supposedly proper vitamin dosage. Some of the questions are subjective and some are based on laboratory examinations to be directed by a physician, but the patients are to decide on their own therapy starting with large but not “mega” amounts. According to self-reassessment every two weeks, the dosage may be increased as much as four to five times the initial amount over eight to ten weeks. The plan is certainly weird, but probably safe, even if expensive.

It is undoubtedly true that medical schools are at fault in not teaching proper nutrition, and it is true that many practicing physicians have too little knowledge of and too little interest in nutrition. It is also true that the world is flooded with books and articles and pamphlets by self-styled nutritionists without adequate knowledge of human behavior and physiology. It is probably true that the average American needs more

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vitamin E, selenium, and vitamin C than are generally consumed. This can be largely corrected by diet; rarely it may be necessary to take these substances in concentrated form.

It is unfortunate that such an able biochemist as the author of this book should present to the public such an exaggerated statement of the known facts and recommend such extreme measures based largely on anecdotal reports or on animal laboratory investigations most of which have not yet been proven for human beings.

LEWIS B. FLINN, M.D.

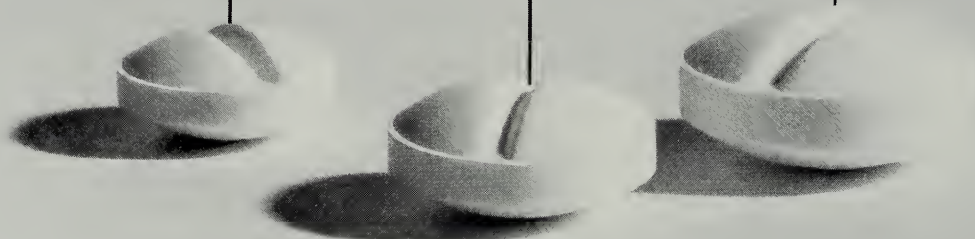
REFERENCES

1. Pryor WA: Free radical pathology—report of Gordon Conference. Chem Eng News, June 7, 1971.
2. Tappel AL: Will antioxidant nutrients slow aging processes? Geriatr 97-105, 1968.
3. Tappel AL: Selenium-glutathione peroxidase and vitamin E. Am J Nutrit 27:960-965, 1974.
4. Packer, Lester, Smith JR: Extension of the life span of cultured normal human diploid cells by vitamin E. Proc Nat Acad Sci 71:4763-4767, 1974.
5. Witting LA: Vitamin E—polyunsaturated lipid relationship in diet and tissues. Am J Clin Nutrit 27:952-959, 1974.
6. Kingsbury KJ, Morgan MD, Stovold R, Brett CG, Anderson J: Polyunsaturated fatty acids and myocardial infarction. Lancet 1:1325-1329, 1969.
7. Horwitt MK: Modern nutrition, in AS Goodhart, ME Shils: Modern Nutrition in Health and Disease: Dietotherapy 5th ed, Philadelphia, Lea & Febiger Publishers, 1974, p 184.
8. The Medical Letter, Vitamin E. 17: August 15, 1975.
9. Pauling L: Are recommended daily allowances for vitamin C adequate? Prac Nat Acad Sci 71:4442-4446, 1974.
10. The Medical Letter, Vitamin C and the common cold. October 11, 1974.
11. Anderson TW, Reid DBW, Beaton GH: Vitamin C and the common cold. J Can Med Ass 107:503-508, 1972.
12. Hume R, Weyers E, Roman T, Reid DS, Hillis WS: Leucocyte ascorbic acid levels after acute myocardial infarction. Brit Heart J 34:238-243, 1972.

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DEATH EDUCATION*

Death Education is a new journal which will publish papers "in the areas of death and dying education, counseling, and care." The second issue includes articles by Orville Kelly, founder of the Make Today Count, Inc., and Sylvia Lack, medical director of Hospice in New Haven. To me the most surprising papers included are "Criteria for Evaluating Curriculum Material in Death Education for Grades K-12"—I didn't know there was such a curriculum—and a study evaluating "Death Attitude Change Resulting from a Death Education Instructioning Unit," which used the Hart Death Attitude Scale and the Wass-Andrews Death Attitude Questionnaire (!) at Emporia State University in Kansas. The author concluded that "favorable death attitude

change can be achieved using a relatively brief death education unit without an introductory health education course."

I imagine this journal will be read by those who need it least. It's \$40 a year to libraries, \$22 a year to individuals.

"Death is more salient and less frightening for the older person" is one of the findings in a study, "The Role of Age in Death Attitude," conducted by interviewing 434 Los Angeles adults.

"Man," wrote La Rochefoucauld, "can look neither at the sun nor at his own death." This journal is apparently dedicated to the proposition of proving La Rochefoucauld wrong.

B.Z.P.

*Wass H: *Death Education*. Washington, DC, Hemisphere Publishing Corporation, 1978.

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Book Reviews

PRINCIPLES & PRACTICE OF MEDICINE, 19th ed, edited by A. McGehee Harvey, M.D., D.Sc., Richard J. Johns, M.D., Albert H. Owens, Jr., M.D., and Richard S. Ross, M.D., Appleton-Century-Crofts, New York, 1976. 1,813 pp. Price \$33.50.

The nineteenth edition of the textbook coming from Johns Hopkins is only about 200 pages longer than the 18th. The organization of the book is exactly the same as the 18th. Incidentally the table of contents is broken down into reasonable subject headings for anyone interested in using it as a starting point for a filing system of general medical information.

The book is very readable. The strength of the book is its charts and tables which present in summary form the information found in the narrative portion.

The book is a complete text for medicine although not encyclopedic; ie, some of the most esoteric subjects are not mentioned, yet the general field of medicine is well covered. The purpose of republishing a text is, of course, to update the text in the light of medical advances. This has been well accomplished in this revision.

All in all this is an excellent text to provide the student with a good working knowledge of general internal medicine.

THE PRACTICE OF MEDICINE: A SELF-ASSESSMENT GUIDE edited by Simeon Margolis, M.D., Appleton-Century-Crofts, New York, 1976. 396 pp. Illus. Price \$11.50.

A companion booklet to *The Principles and Practice of Medicine*, the self-assessment guide fulfills a need. If one is studying a text, it is most helpful to have questions phrased that rearrange the material to pinpoint specific information. This guide does that, also presenting the questions in a manner that is commonly found in examinations. The answers are explained, which makes for further clarification of the major text.

R. WALTER POWELL, M.D.

ETHICS IN MEDICINE edited by Stanley Joel Reiser, Arthur J. Dyck, and William J. Curran, The MIT Press, Cambridge, Massachusetts, 1977. 679 pp. Price \$19.95 Paperback.

This is a large and comprehensive collection of essays culled from varying ages and ethical traditions of the West. It is printed with the support and assistance of the Joseph P. Kennedy Foundation and the National Endowment for the Humanities. A book for selective reading, it supplies both a religious and a humanistic orientation toward ethical questions in the belief that both groups can work together toward mutually agreeable solutions to many moral and ethical problems of contemporary medicine.

The book is divided into six parts, the first two of which attempt to give a general historical and philosophical background to ethics as such, as well as to ethics as applied to medicine. Part I traces the long history of codes of medical ethics from the Greek collections which used to be attributed to Hippocrates, through the medieval modifications of the pagan originals. Generous excerpts are given from the 12th to 14th century codes developed in response to problems of the times. Especially amusing is the discussion of Henri de Mondeville on types of patients and difficulties of remuneration.

The typical mixture of exhortation and professional etiquette which is commonly thought of as "medical ethics" began to take its modern shape in Thomas Percival, a well-known 18th century English physician at the Manchester Infirmary. He had a direct influence on the code of ethics discussed at the first meeting of the American Medical Association in 1846. His viewpoint was opposed by the thinking of John Gregory, Professor of Medicine at Edinburgh in his ethical writings of 1770. Gregory felt that exclusiveness and isolation from the general society was fostered by such closed professional groups. His views were sponsored by Benjamin Rush in the early American period. Jeffrey L. Berland's essay "Medical Ethics and Monopoli-

zation" carry this line of thinking into the present.

Part II introduces the greater part of the book which goes beyond this narrower view of medical ethics and presents general ethics as a systematic intellectual reflection on what is right and wrong based on philosophical and/or religious foundations. Medical ethics, of course, has its own specialized area of reflection as stated in the introduction:

"It is our position that medical ethics is fundamentally grounded in the moral principles and standards of reason that are part of ethics generally, and in the cumulative wisdom and experience of medical knowledge and practice."

A. R. Jonsen and A. E. Hellegers summarize the three essential theories of medical ethics as related to virtue, duties, and justice. These are fleshed-out in excerpts from Mill's Utilitarianism, W. D. Ross's "What Makes Right Acts Right?", and John Rawls' "Justice as Fairness." One notes the omission of libertarian ideas as expressed by Robert Nozick in "Anarchy, State, and Utopia," or organic social thinking along the line of Hegel.

The remainder, and greater, part of the book deals with specific problems of medical ethics: problems of regulation, compulsion, consumer protection; truth-telling in the patient-physician relationship; medical experimentation; procreative decisions; suffering and dying; rights and priorities in the provision of medical care. In summary, this is an outstanding source of material for reflection and decision in the increasingly complex moral questions involved in present day medical care.

W. PHILIP PORTZ, M.D.

THE HOSPITALIZED CHILD by Dene G. Klinzing and Dennis R. Klinzing, Prentice-Hall, Inc., Englewood Cliffs, New Jersey, 1977. 168 pp. Illus. Price \$12.95.

The Doctors Klinzing, both Ph.D.'s, are man and wife, professors respectively at West Chester State College and the University of Delaware. They wrote their book "to help pediatric personnel to meet the emotional needs of hospitalized children through appropriate communica-

tions, behaviors and strategies." I expect their book will probably be used as a text by many types of health personnel in training if not, as the authors think it should, by medical students. For their "hope is that this book can make a substantial contribution to the education of all those who care for children in hospitals."

The chapter bibliographies are excellent. I particularly like the list of books about hospitalization for children. The material on the technical aspects of communication left me cold and unconvinced, but I did enjoy the authors' suggestion about what to do with kids who swear or who tell excessively ghoulish stories on the ward: Remove them.

I know that the Klinzings have been inside hospitals as parents of a pediatric patient, as well as professional observers, and have not approved a great deal of what they have seen. To their credit, their book is full of positive suggestions rather than cavil. It is poignantly illustrated with photos of Wilmington Medical Center pediatric staff and patients, all photographed

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Book Reviews

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1976 YEAR BOOK OF ANESTHESIA edited by James E. Eckenhoff, M.D., D.Sc., Year Book Medical Publishers, Chicago, 1976. 366 pp. Illus. Price \$20.95.

1977 YEAR BOOK OF ANESTHESIA edited by James E. Eckenhoff, M.D., D.Sc., Year Book Medical Publishers, Chicago, 1977. 361 pp. Illus. Price \$20.95.

The 1976 and 1977 Year Books of Anesthesia serve to update information on topics of interest to anesthesiologists. Their format and style remain similar to editions in previous years, and are still edited by the same group of individuals. After a brief introduction, each book has chapters on pharmacology, physiology, anesthetic techniques, equipment, and complications. There are also chapters on monitoring, anesthetic considerations for specific surgical procedures, and a review of respiratory care considerations.

The material in each chapter is based on published works of that year relating to the chapter topic. While the reviews of the included articles do relate to the chapter headings, they are not arranged in any specific sequence or progression. Hence, the reading is somewhat choppy. Editorial comments are used throughout to stimulate thought and place the material in perspective. While this type of presentation is suitable for those with backgrounds in anesthesia, the information may be somewhat difficult to digest without the required background.

Each book is published during the year in which it is issued and the material, in large part, is taken from the preceding calendar year. Hence, the information may be already slightly dated as it is read. For example, the 1977 Year Book begins with an introduction to the SI (Système International) unit system and refers to an article published in 1975.

Despite the above mentioned problems, how-

ever, these books do serve an important and useful function: they are a relatively current source of information for the busy, practicing anesthesiologist. Particularly important editorial contributions are summaries of pertinent articles from other specialty journals.

Another strength of these books is that all of the articles cited, both in the anesthesia and other specialty literature, are clearly referenced. Hence, while the Year Books only summarize the articles, one can easily refer to the original works for more complete information.

In conclusion, the editions are useful sources of summarized information for anesthesiologists and should be used as such.

RICHARD N. HINDIN, M.D.



CONTROL OF COMMUNICABLE DISEASES IN MAN, 12 ed. Edited by Abram S. Beneson, American Public Health Association, Washington, 1975. 412 pp. Price \$4.00 Paperback.

This pocketsize, paperback, inexpensive, semi-official publication of the American Public Health Association reviews briefly all of the communicable diseases in the world. The spectrum is presented in alphabetical order from actinomycosis to yersiniosis and includes the exotic (eg, Pappataci fever) and the commonplace (eg, herpes simplex).

Each disease entity is considered from the standpoint of identification, occurrence, infectious agent, reservoir, mode of transmission, incubation period, period of communicability, susceptibility and resistance, method of control (preventive and therapeutic), epidemic measures, and international measures. While the size of the volume requires that each section be extremely brief, it is valuable to have all of this information incorporated in one volume.

Paperback, pocketsize manuals are convenient for rapid reference. In this instance, however, such convenience is unnecessary since few physicians would require frequent reference to this information. It should be on the shelf of all

public officials and available in a reference library for all physicians.

WILLIAM J. HOLLOWAY, M.D.

❖ ❖ ❖

CLINICAL PROTOCOLS: A GUIDE FOR NURSES AND PHYSICIANS by Carolyn M. Hudak, R.N., M.S., Paul M. Redstone, M.D., Nancy L. Hokanson, R.N., M.N., and Irene E. Suzuki, R.N., M.S., J. B. Lippincott Company, Philadelphia, 1976. 461 pp. Price \$8.75.

This book was written by ten nurses and one physician to fulfill a need at the University of Colorado where there is an Adult Walk-In Clinic which is staffed by nurse practitioners and one medical resident who care for patients described as having "acute, self-limiting problems." (I wish I had the clinical acumen always to know how to classify patients as "acute and self-limited" even before seeing them.) An attending physician is available for consultation.

Two chapters, (Use of Descriptors and the General System Review, and Headache) were written by the physician, and he shared in the writing of another, Development and Utilization of Protocols.

Each of the protocols is prefaced by a box listing diagnoses "which you can't afford to miss." For example, in Chapter 13, Vaginal Discharge, this list includes gonorrhea and ectopic pregnancy. The chapter on Headache proclaims meningitis, intracranial bleeding, and temporal arteritis as the must-not-be-missed concerns. Every protocol lists items to be recorded in the history, objective data to be checked in the physical examination, laboratory examinations and their rationale, and possible diagnoses with differential diagnostic pearls. Also listed are things to be included in the patient's education and follow-up.

This is an interesting book for all doctors who wish to see a very decent outline of what it is they have been doing without ever having written it down; it is a marvelous book for nurses who will be trying to do it themselves. In these protocols, all problems considered beyond the province of the nurses to manage are referred

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by her directly to the physician specialist indicated by the protocol; neither the general internist nor the family practitioner has a role in the ambulatory medical care system so neatly defined in this one paperback volume.

Although the book is sub-titled *A Guide for Nurses and Physicians*, it is dedicated "to those practitioners who pioneered the role and those who will continue to develop it;" I believe this means nurse practitioners. It might also have been subtitled, "How to Be a Doctor without Going to Medical School," but perhaps this is the way medicine will soon be practiced.

I shared it with the nurse practitioner who is part of our office team. Kathlyn Oberly, R.N., M.S.N., says: "The book is, on the whole, good if it is to serve as a guide to the nurse practitioner and not as a cookbook list for making diagnoses. Indeed, because of the references, it has the combined feature of being a resource book as well as an educational guide."

BERNADINE Z. PAULSHOCK, M.D.

DOING BETTER AND FEELING WORSE by John H. Knowles, M.D., W. W. Norton and Company, Inc., New York, 1977. 287 pp. Price \$3.95. Paperback.

This collection of nineteen short essays is subtitled: *Health in the United States*. The book, by presenting the writings of authors such as John H. Knowles, Daniel Callahan, Aaron Wildavsky, and Eli Ginzberg, attempts to cover the entire spectrum of topics relating to our American health system. Indeed, several of the book's contributors are not convinced that there is an American health system and choose to speak of our "non-system."

The organization of this collection of essays is, on the whole, very good. Knowles has grouped the articles in such a manner that those dealing with broader issues are presented first; and, conversely, essays treating more specifically defined areas of concern are presented near the end of the book. Thus Renee C. Fox's "The Medicalization and Demedicalization of American Society" begins the collection while J. B. Richmond's "The

Needs of Children" appears near the end. This method of organization suits the subject matter very well since it allows the reader to deal with the broad and sometimes ill-defined concepts of health and health-care before proceeding to specific health problems of our society.

The major drawback of this organizational scheme is that by grouping together several essays dealing with broadly defined and often overlapping topics, the editor runs the risk of overstating a point. Put in simpler terms, this reader at times felt overwhelmed with the repetitious references to primary care, third-party carriers, HMO's, etc, etc since each essayist introduces and attempts to define these and other concepts in similar, albeit slightly different ways. The impact of all this re-introduction can be tiring, not to mention confusing.

To comment on each of the nineteen essays contained in this volume would be outside the scope of this review. The concepts introduced in Renee Fox's "The Medicalization and Demedicalization of American Society" are significant in that they provide a fresh and, I believe, important view of how health-care systems relate to the society they serve. Robert H. Ebert in "Medical Education in the United States" does an excellent job of discussing the historical development, present status, and future implications of our training system for physicians and other health professionals. Dr. Knowles, in "The Responsibility of the Individual," seems to me too often to deal in assumptions not well-grounded in fact, yet, his message is an important one: the actions of the individual and of the society limit the effectiveness of any health-care delivery system.

Doing Better and Feeling Worse doesn't contain all the solutions to all our health-related problems; it doesn't even completely discuss them all. What it does and does well is give a stimulating and rather comprehensive overview of the problems, and perhaps some of their solutions, in dealing with "Health in the United States."

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THE MENOPAUSE BOOK by Barrie Anderson, M.D., Elizabeth Connell, M.D., Helen S. Kaplan, M.D., Nancy Kemeny, M.D., Milkah Notman, M.D., Johanna Perlmutter, M.D., Natalie Shainess, M.D., and Mary Catherine Tuson, M.D., Hawthorne Books, Inc., New York, 1977. 256 pp. Price \$12.50.

The first chapter is loaded with the kind of knowledge I adore: Among the Mohave women "menopause is a sign of achievement; Mohave women are free to work, to flirt, and to be wise during their middle years"; according to a Chinese psychiatrist, menopausal psychoses are unknown in China where older women have secure and coveted positions.

Also of interest is a table which lists all the symptoms blamed on menopause and compares their prevalence in a group of menopausal and pre-menopausal women. More of the post-menopausal women had no complaints at all, and apparently women who are still menstruating have more concern and fear about the menopause than women who have been through it.

An attitude of anxiety and depression during perimenopausal years is much more common in American women than in British, French, or German women; whether it is so or not, 85% of British women consider themselves still attractive to men after menopause.

The ten chapter headings are: What Is Menopause; Temporary Symptoms and Permanent Changes; The Emotional Element; Estrogen: What to Do Until the Results Are in; Hysterectomy; Breast Cancer; Sex at Menopause; Is There a Male Menopause? (I'll not tell you the answer); Helping Nature: Diet, Exercise, and Cosmetic Surgery, and Women Talk about Menopause. As these are all topics of importance to women, this book will undoubtedly have a wide readership although some of the pronouncements are not as crisp as they should be. For example, the chapter on Breast Cancer closes with this sentence: "In summary, breast cancer is a curable disease." I would have felt better if the word often had been included.



American Medical Association

This book was allegedly written by eight women physicians and edited by Louisa Rose. Although none of the individual chapters is signed, Chapter 7, Sex at Menopause, alone bears a footnote, "This chapter was written from a series of interviews with Helen Singer Kaplan, M.D. . . ." I have a hunch that probably all of the chapters were so prepared, which perhaps accounts for the book's readability as well as its abundant inclusion of anecdotal case reports. Should the eight doctors have allowed their names on the jacket and frontispiece if the prose is not really theirs but rather prepared from interviews? I think not.

BERNADINE Z. PAULSHOCK, M.D.

✱ ✱ ✱

IMPLEMENTING THE PROBLEM-ORIENTED MEDICAL RECORD, 2nd ed. Edited by Jay S. Wakefield and Stephen R. Yarnall, M.D., Medical Computer Services Association, Seattle, 1976. 130 pp. Illus. Price \$10.00 Paperback.

This is a rather dramatically edited presentation of the "problem-oriented" concept in medical records, followed by four pages of advertisements, price lists, and postpaid order forms. It contains a large number of lively and highly practical direct quotes from Dr. Lawrence Weed, the "High Priest" of Problem-Oriented Record Keeping. An example of Dr. Weed's advice, particularly appealing to the reviewer, who has been promoting a problem-oriented system in a traditional institution in recent years, occurs on page 62: "When you start to discipline people, never talk in a bureaucratic language about numbers, pages, and this sort of thing. They kind of like you to be bureaucratic so they can tell you how busy they are. Never talk to the physician about form, titling, etc. . . . they can't stand that sort of old-maid approach. If you can follow easily, and from what you can see, it is in pretty good shape, leave him alone."

This is not a book for the beginner in POMR, but would be of interest to workers in this field, as a down-to-earth presentation of specific problems and answers.

ROBERT W. BUCKLEY, M.D.

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ANNUAL REVIEW OF PHARMACOLOGY AND TOXICOLOGY Vol. 16 edited by Henry W. Elliott, Annual Reviews, Inc., Palo Alto, California, 1976. 566 pp. Price \$15.00.

The *Annual Review of Pharmacology and Toxicology* is written and edited by a select group of scientists who are not physicians. The material is conveniently organized by organ system and has a refreshing, clinical flavor throughout most of the chapters.

I found the sections on selective immuno-suppressants and therapeutic implications of bio-availability interesting and sufficiently general for the ordinary practitioner (ie, me). The only criticism one could find for such a volume is its brevity . . . but this is really one of the true virtues of such a volume.

I can heartily recommend this book as a fine reference book for the Delaware Academy of Medicine library for it can serve as a source for useful bibliography for future investigation.

ROBERT ABEL, JR., M.D.

In Brief

Speakers on "Ask the Doctor"

Speakers for April 1978 on the Tuesday radio program (11:05 a.m., WDEL) produced by the Medical Society of Delaware are: April 4, *Ted E. Chronister, M.D.*, Services for Epileptics; April 11, *Henry R. Cowell, M.D.*, Autotransfusions for Surgery; April 18, *Donald H. McGee, M.D.*, Immunizations; April 25, *Edward R. Sobel, D.O.*, Utilization Review.

CLINICAL NOTICES AND MEETINGS

Advances in Diagnostic Gastroenterology

Health Projects International Inc. in cooperation with the University of Pennsylvania will present an all-day program on ADVANCES IN DIAGNOSTIC GASTROENTEROLOGY, April 26, at the University of Pennsylvania Annenberg Auditorium, Philadelphia, Pennsylvania. For information contact: Health Projects International Inc., 60 East 42nd Street, New York, New York 10017. Telephone: (212) 682-0705.

Genetic Meeting

The Alfred I. duPont Institute will host the EASTERN REGIONAL MEETING OF THE ASSOCIATION OF CYTOGENETICS TECHNOLOGISTS, Region III, April 29, at the Institute. The meeting is open to any person involved in cytogenetics. The meeting and luncheon are free. Dr. Laird Jackson, Director of the Division of Medical Genetics of Thomas Jefferson University, will discuss the need for cytogenetic analysis, the need for genetic counseling, and where these services are available in our community. Dr. Henry Cowell will speak on Cytogenetic Abnormalities in Orthopedic Conditions and will moderate a panel discussion on this topic. For information contact: Ms. C. E. Clark, Supervisor, Clinical Research, Alfred I. duPont Institute, P.O. Box 269, Wilmington, Delaware 19899. Telephone: 571-1000.

Hospital Conference and Forum

Estes Park Institute presents the 8th ANNUAL HOSPITAL MEDICAL STAFF CONFERENCE AND HOSPITAL TRUSTEE FORUM, May 21-25, Sun Valley, Idaho. The Conference is sponsored by the Northwest Hospitals Education and Research Alliance. It is designed for the benefit of physicians who are in leadership positions in community hospitals. For information contact: C. Wesley Eisele, M.D., Estes Park Institute, P.O. Box 400, Englewood, Colorado 80151. Telephone: (303) 761-7709.

A. I. duPont Spring Seminar

The Alfred I. duPont Institute will present the ANNUAL SPRING SEMINAR, May 20, at The Institute. For information contact: Mrs. Deirdre O'Connell, Alfred I. duPont Institute, P.O. Box 269, Wilmington, Delaware 19899.

ACP Postgraduate Courses

The American College of Physicians will sponsor the following courses. Each program will fulfill Category I requirements for the AMA Physician's Recognition Award. For information contact: Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

ADVANCES IN CLINICAL MEDICINE, May 8-12, Yale University School of Medicine, New Haven, Connecticut.

RECENT PROGRESS IN CLINICAL ENDOCRINOLOGY: PHYSIOLOGICAL APPROACH TO DIAGNOSIS AND TREATMENT, May 8-12, University of Michigan Medical School, Ann Arbor, Michigan.

CLINICAL AUSCULTATION OF THE HEART, May 10-12, Georgetown University Medical Center, Washington, D.C.

NUCLEAR MEDICINE FOR THE INTERNIST, May 10-12, Mayo Clinic and Mayo Foundation, Rochester, Minnesota.

RHEUMATIC DISEASES: CLINICAL ASPECTS AND BASIC MECHANISMS, May 15-19, Colonnade Hotel, Boston, Massachusetts. Also sponsored by Harvard Medical School and Robert B. Brigham Hospital.

MULTIDISCIPLINARY MANAGEMENT OF SOLID TUMORS, May 22-24, Mayo Clinic, Rochester, Minnesota.

HEMATOLOGY UPDATE 1978, May 22-24, Mayo Clinic, Rochester, Minnesota.

REVIEW OF THE OLD AND NEW IN THE DIAGNOSIS AND THERAPY OF INFECTIOUS DISEASES, May 22-26, Alton Ochsner Medical Foundation, New Orleans, Louisiana.

CLINICAL CARDIOLOGY—UPDATE 1978, May 31-June 3, Vancouver, British Columbia.

NEUROLOGY FOR INTERNISTS AND FAMILY PHYSICIANS, May 31-June 3, Bowman Gray School of Medicine of Wake Forest University, Winston-Salem, North Carolina.

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In Brief

Suicide Prevention and Crisis Intervention

The International Association for Suicide Prevention will present the 10th INTERNATIONAL CONGRESS FOR SUICIDE PREVENTION AND CRISIS INTERVENTION, June 17-20, 1979, Ottawa, Ontario, Canada. The theme of the 10th Congress will be "Basic Issues." The call for papers will be issued May 1 and prospective contributors who wish advance information may contact: Dr. Terry Firth, Congress Program Chairman at the Secretariat. For further information contact: Secretariat, IASP Congress '79, Suite 700, 71 Bank Street, Ottawa, Ontario, Canada, K1P 5N2. Telephone: (613) 238-4079. There is a reduced advance registration for those who pay a 20% deposit before June 30. Potential delegates are urged to register as early as possible.

Nutrition in Cancer

The American Cancer Society and the National Cancer Institute will present the NATIONAL CONFERENCE ON NUTRITION IN CANCER, June 29-July 1, Seattle, Washington. The purpose of the conference is to inform the general medical community of recent developments concerning the role of nutrition in cancer. Approved for 15 Category I Credit Hours for the AMA Physician's Recognition Award, 15 Elective Hours for the AAFP, and CME Credit Hours in Category 2-D by the AOA. For information contact: Sidney L. Arje, M.D., American Cancer Society, Inc., 777 Third Avenue, New York, New York 10017.

Clinical Neurology

The Department of Neurology, Vanderbilt University School of Medicine will present the First Annual Postgraduate Course, CONTEMPORARY CLINICAL NEUROLOGY, July 6-9, Hilton Head Island, South Carolina. Approved for 15 Category I Credit Hours for the AMA Physician's Recognition Award. For information contact: Vanderbilt Continuing Education, 305 Medical Arts Building, Nashville, Tennessee 37212. Telephone: (615) 322-2716.

Diseases of the Chest

The International Academy of Physicians and Surgeons Affiliated with the American College of Chest Physicians will sponsor the XIII WORLD CONGRESS ON DISEASES OF THE CHEST, July 2-7, Kyoto, Japan. Four physicians have been selected by the Awards Committee to be honored during the Kyoto Congress. For information contact: Alfred Soffer, M.D., Executive Director, American College of Chest Physicians, 911 Busse Highway, Park Ridge, Illinois 60068.

Pediatric Symposium

Children's Hospital National Medical Center and George Washington University School of Medicine will sponsor the FIFTH ANNUAL SYMPOSIUM ON RECENT ADVANCES AND COMMON PROBLEMS IN PEDIATRICS, May 10-12, at Children's Hospital in Washington, D.C. The program is approved for 18 credit hours in Category I of the Physician's Recognition Award of the AMA and 18 hours of elective credit by the American Academy of Family Physicians. For information contact: Mrs. Susan Weiss, 13407 Brackley Terrace, Silver Spring, Maryland 20904.

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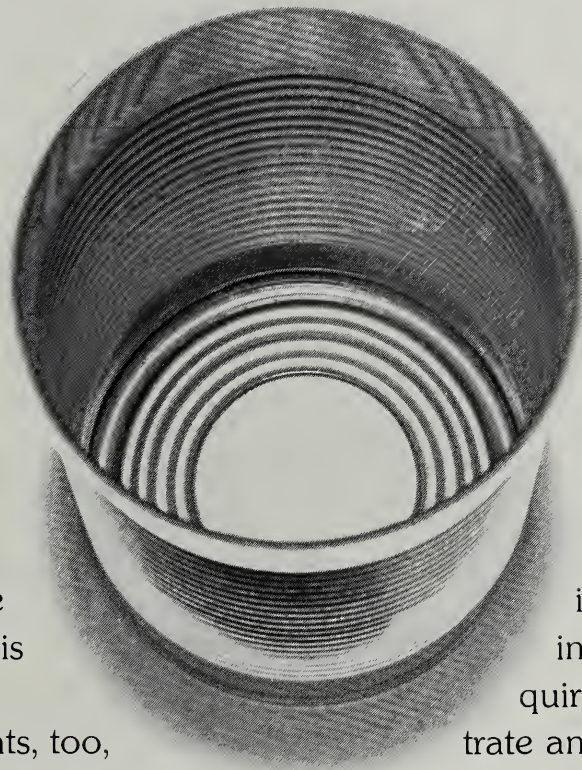
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cancer communiqué

FROM THE DELAWARE CANCER NETWORK*

CANCER CONTROL PLAN FOR THE STATE OF DELAWARE

THOMAS C. FEDEWA, PH.D.

In recent years the month of April has been nationally proclaimed as Cancer Control Month. The purposes of such a proclamation certainly include the fact that all of us need to be reminded in a special way of the importance of taking increasing personal responsibility for our own health and well being. In addition, those of us who are involved in a specialized way in the promotion and delivery of specialized health services ought to review once again the purposes of our efforts. In line with this, it is appropriate to summarize the history, stated purposes, goals, and objectives of the Delaware Cancer Network.

The current state of the Network and its program is the result of an exciting organic process which received initial impetus from continuing efforts by interested individuals and groups, including the Delaware Division of the American Cancer Society, to respond locally to the National Cancer Act of 1971. The early seeds of the Network lay in a resolution of the Board of Trustees of the Wilmington Medical Center to form a Cancer Study Committee. This committee would examine the possible establishment of a specialized disease-oriented program having a statewide focus. Further, these programs

would be tailored to meet a variety of cancer control requirements as experienced locally by both interested persons and institutions. By 1975, planning had moved to the point that a local staff could be hired and separate programs could be brought together under the umbrella of this "new kind of agency" . . . a Network. In 1977, the By-Laws of the Network were formally ratified by the Network Advisory Board.

The Preamble to the Network By-Laws states the purpose of the By-Laws in providing for the orderly conduct of the activities of the individuals and institutions participating in planning and providing cancer control activities.

The purpose of the Network, as an organization, is to develop and operate community-based cancer programs and a network of improved cancer detection, diagnosis, treatment, and rehabilitation programs for the State of Delaware and geographically contiguous areas. This task is to be accomplished through the following objectives:

1. To minimize the illness, disability, suffering, and death due to cancer among the population served.
2. To provide access to optimal cancer management for these cancer patients.

Dr. Fedewa is the Associate Director for Administration of the Delaware Cancer Network.

*An NCI-supported agency located at 1200 Jefferson Street, Wilmington, Delaware 19801. Tel. (302) 428-2113.

3. To identify high-risk populations and to make available high-quality detection, diagnostic, and treatment services through the patient's source of primary medical care.
4. To define and maintain standards of diagnosis and treatment of cancer which are uniformly high so that the patient receives the same quality of care regardless of where he is treated or how he enters the health-care system.
5. To devise programs tailored specifically to treat cancer patients of all ages.
6. To foster continued progress of cancer research and also the effective translation of appropriate research results into clinical practice.
7. To foster the training of physicians and other personnel to insure continued availability of care and the minimization of cost consistent with quality care.
8. To foster the development of a cooperative network of physicians and institutions which will provide mutual support and conduct programs in rehabilitation (social, emotional, vocational, and physical) as well as cancer prevention and public education.
9. To maintain a system of evaluation and to periodically assess Network effectiveness on a local and national level.
10. To plan for the development of a comprehensive cancer center for Delaware.

Today, these goals and objectives are being met through twelve separate and identifiable programs in applied research, and through disease-site-specific programs for cancers of the breast, colon, rectum, and the female genital tract and service-oriented programs including professional and public education, nursing services, rehabilitation services, pastoral care services, screening services, and social work services.

Currently, there is a strong cancer control program for the State of Delaware. The Network includes formal agreements with non-governmental hospitals in the State as well as with non-hospital community health-care providers. These developments represent another significant point in the continued attention to state-of-the-art cancer services. This cancer control effort should be and can be continued in the future.

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Usage in pregnancy Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, PERCODAN® should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Usage in children PERCODAN® should not be administered to children.

Salicylates should be used with caution in the presence of peptic ulcer or coagulation abnormalities.

PRECAUTIONS **Head injury and increased intracranial pressure** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions The administration of PERCODAN® or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special risk patients PERCODAN® should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

Phenacetin has been reported to damage the kidneys when taken in excessive amounts for a long time.

ADVERSE REACTIONS The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

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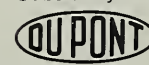
DOSAGE AND ADMINISTRATION Dosage should be adjusted according to the severity of the pain and the response of the patient. The usual adult dose is one tablet every 6 hours as needed for pain.

DRUG INTERACTIONS The CNS depressant effects of PERCODAN® may be additive with that of other CNS depressants. See WARNINGS.

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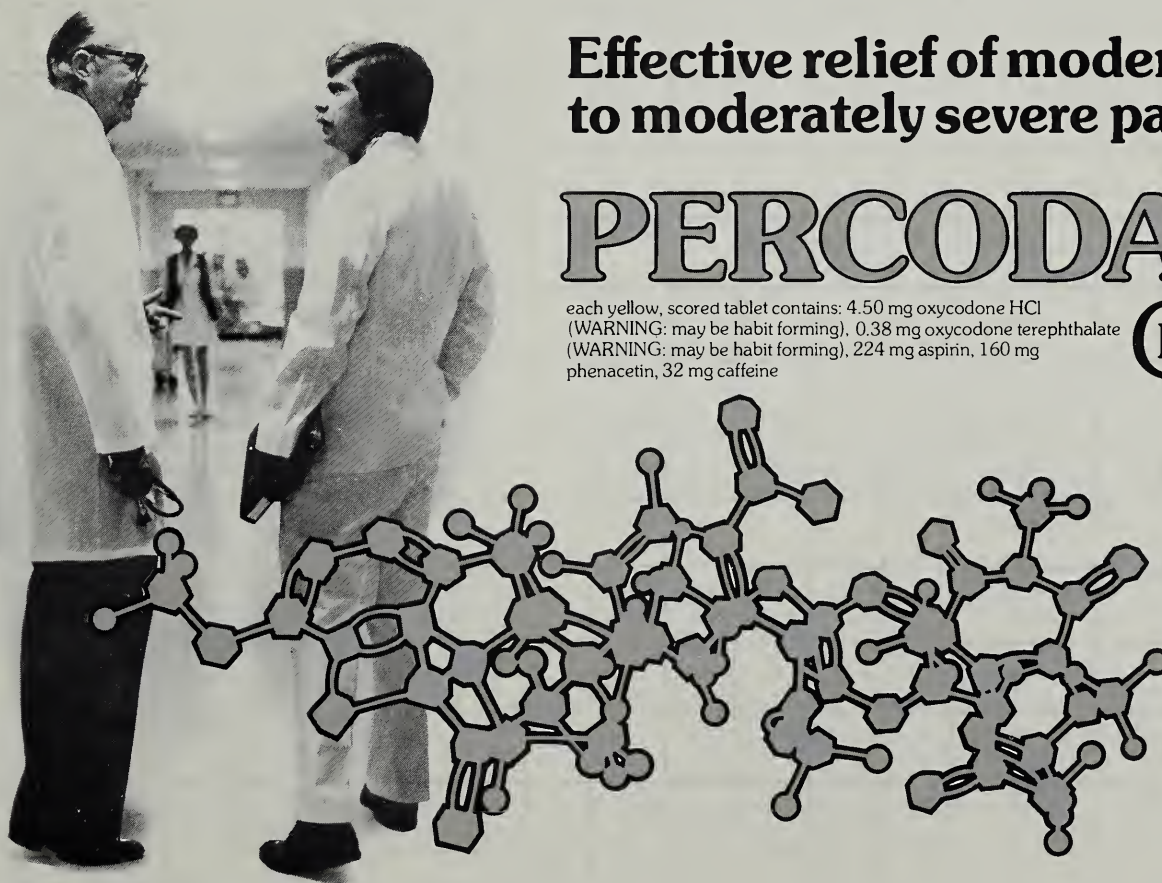
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Consider PERCODAN® because patients rarely ask for increased dosage. PERCODAN® relief can last up to six hours—until time for next tablet.

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Copy should be typewritten, double-spaced on 8½" x 11" white bond paper. In addition to the original, two copies are desirable.

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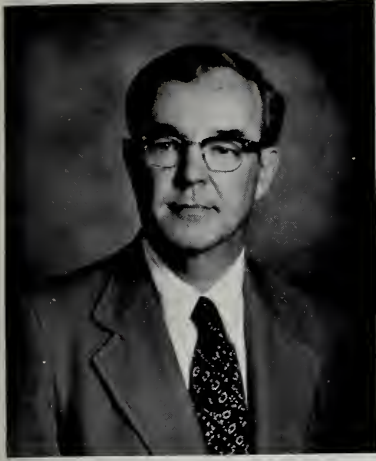
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Generic names should be used, but if an author uses a brand name drug in the the course of a study, or wishes to use a brand name for other reasons, he may do so, but should insert it (in parentheses) after the generic name.



President's Page

SORRY YOU WEREN'T INVITED

Recently Irving Shapiro, Chairman of the Board of E. I. duPont de Nemours & Company, hosted a reception at the Wilmington Country Club to introduce the officers of the Gannett Company which had just purchased the Wilmington daily newspapers.

The club was crowded with several hundred Delaware businessmen, lawyers, legislators, labor leaders, state officials, and others. It startled me a little bit that I was the only physician in the room.

As President of the Medical Society of Delaware, which has an obvious concern about the effectiveness and control of our major communications system, I was pleased to be on hand and felt reassured that the change of ownership will not lessen the responsible and cooperative newspaper relationship we have enjoyed with the previous ownership. The objective and comprehensive coverage of the News-Journal papers has helped forge a better medical system in Delaware. We look forward to working with them for continuing improvement and the achievement of even higher goals.

I also felt a vague uneasiness that no other members of my own profession were on hand. It made me wonder if, in our major commitment to do everything in our power for the health and recovery of our patients, we do not sometimes isolate ourselves from broader community involvement.

Donald Barnhouse alluded to the danger inherent in such isolation when he spoke at our

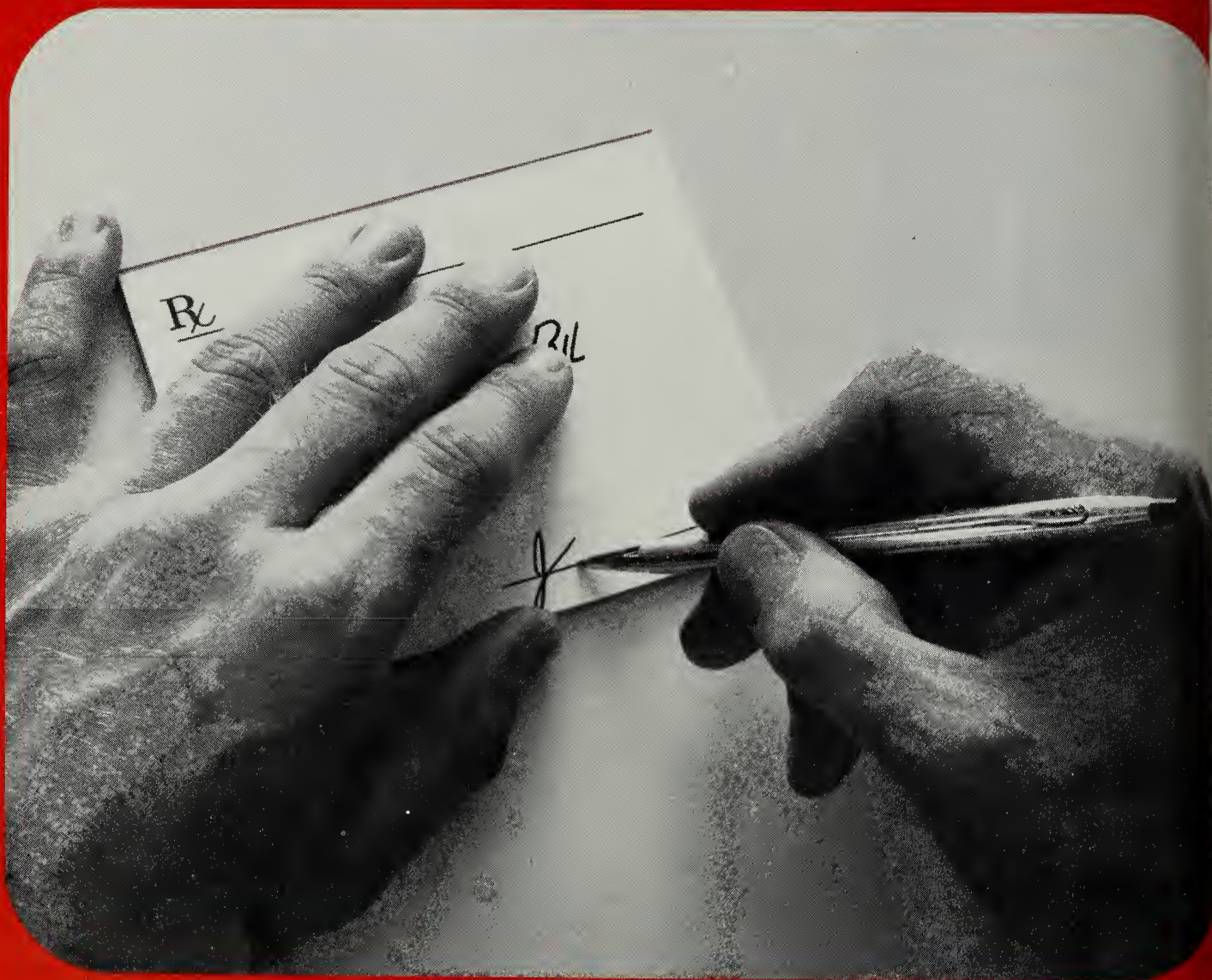
annual meeting last October on the excellent theme, "How to Avoid Political Rape." Barnhouse, a longtime newsman and political activist, has always been well aware that indifference and detachment are the characteristics which permit others to make and enforce decisions which actually should remain with us.

There can be no quarrel with the overriding thesis that a physician's first loyalty is to his or her professional oath to take care of those in need of such services.

There are also gains to be made for our profession as well as for each of us individually by community service and participation. The public-spirited service clubs, the political parties, the civic and good government groups, and many others are constantly looking for members who will give of their time for a worthwhile cause or project. Let us by no means back off in any respect from our priority commitment to provide the people of Delaware with the highest possible standards of medical care, attention, and treatment, but let us not overlook the fact that we share a bond of citizenship with everyone else; it is incumbent upon us to do our share toward the attainment of ever better communities in which to live and work, raise our families, and share our friendships.

John J. Egan, M.D.

There is no substitute



yours...

Contraindications: Anuria; hypersensitivity to this or other sulfonamide-derived drugs.

Warnings: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy.

Use in Pregnancy: Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults.

Nursing Mothers: Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.

Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting ex-

cessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hypokalemia may develop, especially with brisk diuresis, in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, or with inadequate oral electrolyte intake. Hypokalemia can sensitize or exaggerate response of heart to toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice. Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal im-

GENETICS IN CLINICAL MEDICINE

PETER A. DUNCAN, M.D.

In recent years a unique specialty has evolved in medicine: the investigation of congenital malformations and genetic diseases. This specialty not only has a core of full-time medical and paramedical personnel but also involves a large variety of specialists on a part-time basis. In contrast to many other fields in medicine, the scope of diagnostic activity in malformation and genetic diseases involves many specialties. As a result of this, a number of Birth Defects Centers or Medical Genetics Departments have been established in institutions in this and other countries. These organizations usually function as a team to study a large variety of rare diseases, with the family rather than the individual as its basic unit of interest. New techniques in cytogenetics, biochemistry, tissue culture, and fetal medicine and the resurgence of interest in genetics have provided the stimulus for the development of these centers; but, of equal importance, have been the skills of the clinician.

The sophisticated laboratory equipment and the substantial funding required for laboratory research practically eliminate such investigation from the usual sphere of activities of the practicing physician. While this research is and will be required in the diagnosis and management of many birth defects, there is still ample opportunity for the careful clinical delineation of mal-

formations for the purpose of establishing their diagnosis, genetic implications, possible clinical markers, and other additional features.

See editorial comments on page 233.

For most practitioners, it is probably not worth the effort to become familiar with these many rare diseases. The availability of a Birth Defects Center will enable them to utilize these facilities in the care of their patients and families with malformation and/or genetic defects. In this presentation, some of the clinical activities of a Birth Defects Center organized to provide general malformation and genetic services in a seven-county region will be discussed.

Birth Defects: Age of Onset

Anomalies such as cleft lip/palate or imperforate anus are readily visualized at birth, but heart or renal abnormalities may not be detected for a variable period postnatally. The pedigree in Figure 1 is that of an autosomal dominant disease, medullary cystic disease, which does not become clinically evident until renal failure occurs somewhat suddenly in the third to fifth decades of life. Because its etiology is dependent on the transmission of genetic material from one generation to the next, it is classified as a genetic birth defect. It is hoped that future research will permit the recognition and treatment of the ever-increasing number of family members at risk for this disease as is evident in the fourth generation of this pedigree. Early detection of

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Adapted from a presentation to the Veterans Administration Hospital, Elsmere, Delaware.

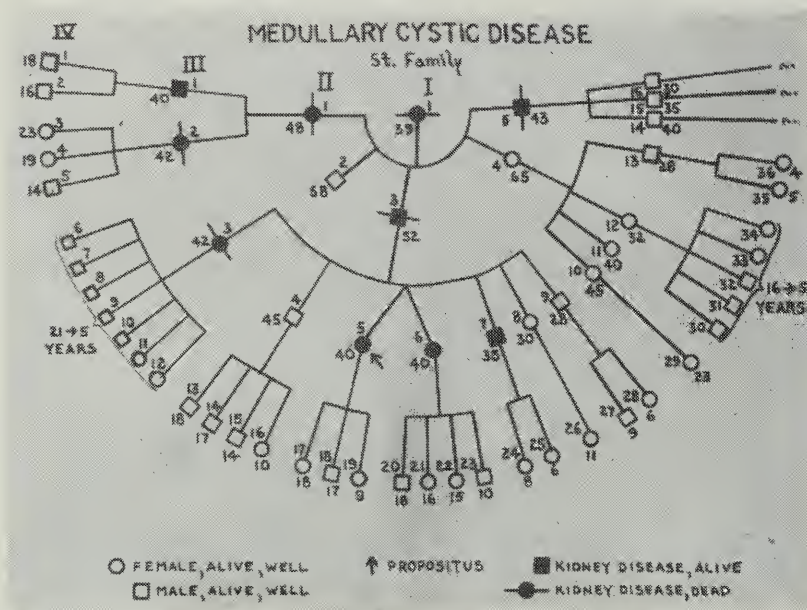


FIGURE 1

Pedigree of family with autosomal dominant medullary cystic disease.



FIGURE 2

Amputations and ring strictures of fingers of left hand attributable to intrauterine band formation.

the disease itself might also limit its dissemination.

Examples of Patients Examined in a Birth Defects Center

Birth defects are caused by a variety of etiologic agents. Their specific identification is a logical approach to their eventual treatment or prevention. It is most important that the diagnosis be defined as accurately as possible.

We recently evaluated the child of a woman who was about to have her tubes tied because of the multiple malformations which had occurred in her firstborn child. She and her husband were young and desired further children. The abnormalities proved to be of a type attributable to intrauterine band formation and not known to recur in a family.¹ (Figure 2) Although a remarkable habilitation of the deformities in the son had been performed, their physician had not provided the parents with the genetic information they both desired. This entity and another non-recurring abnormality, arthrogryposis,² are seen relatively frequently in a Birth Defects Center. (Figure 3)

In another family, the Sanfilippo syndrome was identified in the first child of a young couple desiring further children.³ The major feature of concern in this autosomal recessive mucopoly-

FIGURE 3

Feet of patient with arthrogryposis multiplex congenita.



saccharide disease is mental retardation and its recurrence risk of 25%. Clinically and radiologically identical, two types of the Sanfilippo syndrome are now separable biochemically. The specific enzyme defects in these two types are also identifiable in cells cultured from the amniotic fluid. Because of the limited time period available to grow a sufficient number of amniotic cells, it is essential to have prior knowledge of the specific enzyme defect in the presenting patient (propositus) to insure proper prenatal diagnosis.

Additional features of birth defects are sought in a Birth Defects Center. Recently, a seven-year-old retarded boy was intermittently recorded to have serum sodiums as high as 170 mEq/l. His prior classification was a "retarded child with a cleft lip/palate." His flat mid-face, mild hypotelorism, and unilateral cleft lip/palate suggested the possibility of holoprosencephaly,⁴ but this was discounted by other observers because of the minimally abnormal facial features and his longevity. Facial morphology in holoprosencephaly varies from cyclopia, its severest form, to a minimal expression characterized by hypotelorism associated with bilateral cleft lip/palate, and nearly all patients die in early infancy. Support for the diagnosis of holoprosencephaly was elicited by the finding of intermittent hypernatremia in several patients with

documented holoprosencephaly, and clearly established by a computerized tomographic demonstration of a single anterior cerebral ventricle. Inasmuch as holoprosencephaly has been recorded to occur as an autosomal recessive disease in some families, its diagnosis in this mild form may be of significance in genetic counseling.

Birth Defects Centers are interested in the study of spontaneous abortions, stillbirths, and early neonatal deaths. Their accurate diagnosis can be of considerable significance to a family in its approach to future pregnancies. While approximately 40% of the fetuses of first trimester spontaneous abortions have chromosome aberrations, these must largely occur "de novo" as they are found in only 2 to 5% of parents experiencing multiple spontaneous abortions. Figure 4 illustrates a 3/8 balanced translocation found in a mother who had four first trimester abortions and a stillbirth with multiple severe anomalies.

A meningomyelocele was found in an 18-week-old aborted fetus referred to us for study. This disorder has a recurrence risk of 5% which contrasts with its incidence of one per 1000 live births in the general population, and can now be diagnosed prenatally by an elevated alpha-feto-protein determination of the amniotic fluid. On our advice this parameter was monitored in the

next pregnancy and was normal. Families have to be advised, however, that a normal alpha-fetoprotein determination excludes only approximately 90% of the neural tube defects since the remainder are covered by skin and, for that reason, are not associated with elevated alpha-fetoprotein levels.

Recently we investigated a nine-month-old retarded infant in whom seizures were first noted at the age of four months. The observation of cafe-au-lait spots in the baby's skin raised the possibility of neurofibromatosis. Inasmuch as neurofibromatosis is an autosomal dominant disease, both parents were inspected. Although previously unaware of them, the father was found to have neurofibromata, which were histologically verified by biopsy. Thus, confirmation of the neurofibromatosis in the infant was established through its genetic manifestations in the father.

Syndrome Identification

Identification of syndromes and determination of their genetic significance constitutes an important function of a Birth Defects Center. A syndrome is best defined as a non-random association of malformations as illustrated in the diagnostic sequence experienced in the following family.

A five-year-old boy was evaluated because of a parental request for genetic counseling concerning his penile hypospadias. Of great significance to us, when he was first examined, was the presence of a ventral or shawl scrotum. (Figure 5) To date, this developmental anomaly is only known to occur in the Aarskog syndrome.⁵ Such patients have a characteristically round face, hypertelorism/telecanthus, a small nose with anteverted nostrils, and an increase in the nasolabial distance. They have short fingers and clinodactyly of their fifth fingers, which by x-ray is attributable to hypoplasia of the middle phalanx. This patient not only had the radiographic vertebral malformations frequently seen in this disease but also had an asymptomatic intervertebral disc calcification which rarely occurs in children. Both this latter abnormality and the penile hypospadias have not been previously recorded in this syndrome.

The Aarskog syndrome is inherited in an X-linked recessive fashion. For this reason we examined the patient's only sib, a brother, whom the parents had considered to be entirely normal. He also had the ventral scrotum, clinodactyly, and vertebral and rib anomalies similar to those of his brother. Measurement of their upper segment/lower segment ratios revealed short lower extremities in both the boys, a common feature

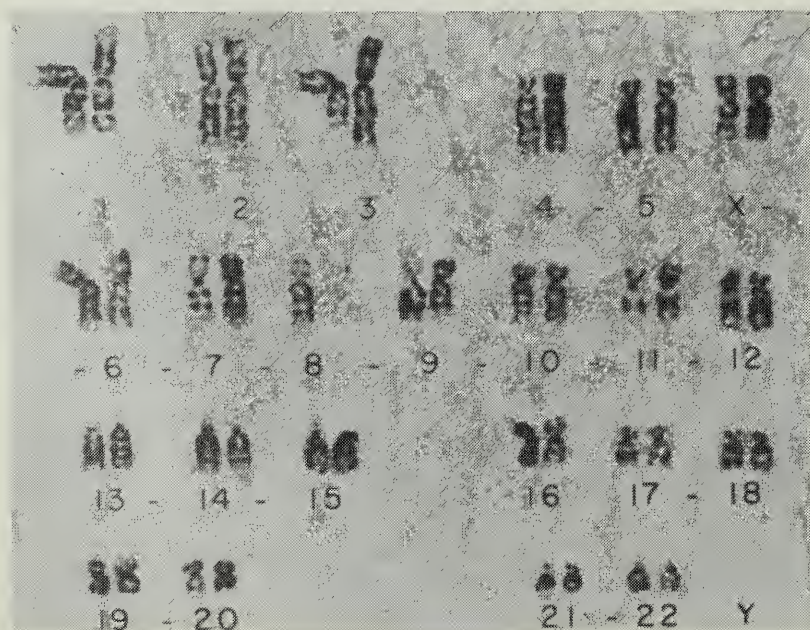


FIGURE 4

Balanced 3/8 translocation karyotype of mother with repeated spontaneous abortions.

of this syndrome. While the Aarskog syndrome was not described until 1970, approximately 13 families with this syndrome are now documented in the literature.

Malformations Associated with Chromosomal Aberrations

In our region, newborns with malformations are seen in their local hospitals at the request of their physicians. This serves two purposes: it permits confirmation of the clinical impression and the obtaining of blood specimens for a chromosome study. The most frequent clinical chromosomal problem encountered is the Down syndrome, which occurs once in every 600 live births. Determination of the karyotype is now an absolute requirement, not only to confirm the clinical diagnosis but also to establish the specific type of chromosomal abnormality. Increase in recurrence risks vary from 1 in 100 following a sporadic trisomy 21, to 1:5 (female) or 1:20 (male) for a 15/21 translocation carrier, to 100% for a 21/21 translocation carrier. Upon completion of the chromosome studies, both the medical and genetic implications of the diagnosis are discussed with the parents in one or more counseling sessions.

Future pregnancies in a family at risk for chromosomal abnormalities may be monitored, if desired, by amniocentesis for the purpose of prenatal diagnosis. This is now offered to translocation carriers, to all women 35 years of age or older, and to those couples who have had a previous child with a chromosome abnormality.

A less appreciated indication for chromosome studies is in the evaluation of children who are of short stature for their family size. One such nine-year-old girl, without evidence of the Turner phenotype or other abnormalities, was found to have an 45,X/46,XY mosaic karyotype. Because of the high risk of malignancy when an XY cell line is associated with intra-abdominal gonads in a phenotypic female, exploratory laparotomy was performed. Gonadoblastoma was found microscopically in the gonadal streaks removed at operation.⁶ This patient is now receiving endocrine therapy to simulate a normal female phenotype and is gradually being advised of her reproductive deficit.

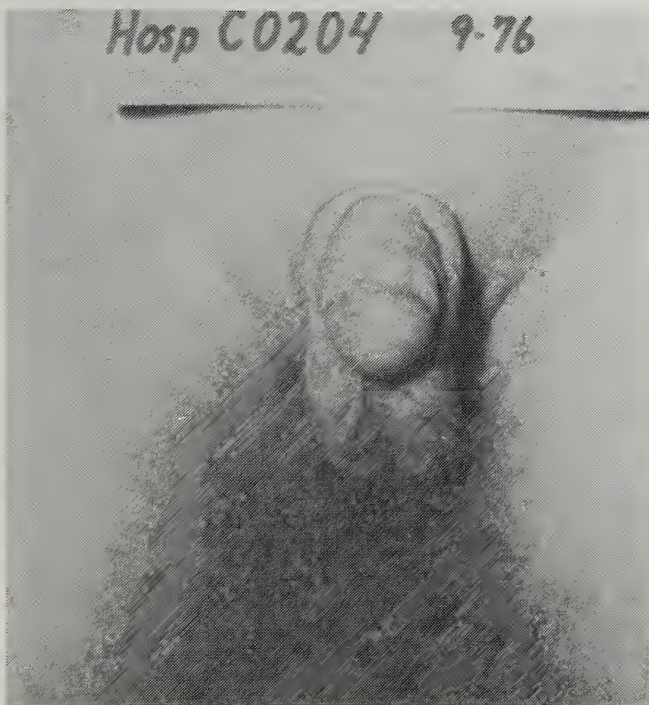


FIGURE 5

Ventral or shawl scrotum in a patient with the Aarskog syndrome.

Monitoring of Neoplasia Associated with Syndromes

Monitoring must be performed for treatable neoplasia known to have an increased occurrence when associated with certain syndromes. As an example, an adult was counseled for an established basal cell nevus syndrome.⁷ This disorder is identified by the presence of jaw cysts and/or skin lesions which, however, do not appear until the second decade of life or later. These patients also have associated congenital anomalies which include macrocephaly with frontal and parietal bossing, hypertelorism/telecanthus, and rib and vertebral malformations. Since this is an autosomal dominant disease, the client was advised that any offspring he might have would have a 50% risk for this disorder. We recently saw his five-month-old son and diagnosed the basal cell nevus syndrome on the basis of the congenital abnormalities noted above. In spite of its known genetic transmission, this disorder has rarely been detected in infancy and, in most instances, has been recognized subsequent to the finding of a medulloblastoma. For this reason,

our child will be closely monitored for such a tumor over a period of several years.

Another example would be the monitoring for Wilm's tumor in syndromes such as congenital asymmetry, the Beckwith-Wiedemann, or the sporadic type of congenital aniridia. While monitoring for a Wilm's tumor in a child with congenital asymmetry, we found bilateral medullary sponge kidneys. This defect also has a known association with congenital asymmetry but previously had been detected only in adults.

Cleft Palate Team

Our Birth Defects Center also coordinates the activities of the Cleft Palate Team; this permits the identification of significant associated malformations in the cleft patients. Most cleft lip/palate patients relate to a multifactorial mode of inheritance, a form of genetic transmission believed to result from an interaction of multiple genes with different environmental agents. The genetic factors have been reasonably well established, but until recently the environmental factors were largely theoretical. Because of associated facial features and aplasia/hypoplasia of the nails in three recent patients, the usage of anti-convulsive drugs by the mother during the preg-

nancy was correctly predicted. The usual 5% recurrence risk associated with the multifactorial type of cleft lip/palate can be as high as 50% when the facial clefting is associated with malformations such as lip pits or filiform fusion of the eyelids since these syndromes are inherited in an autosomal dominant fashion. Some 75 syndromes are known to be associated with cleft lip/palate malformations.⁸

Craniofacial malformations such as the Crouzon or Apert syndromes are now being evaluated at cleft palate centers. Increasing efforts for their cosmetic habilitation are being made through the activities of these teams.⁹

REFERENCES

1. Diamond LS: Ring constrictions, in Bergsma D (Ed): *Birth Defects: Atlas and Compendium*. Baltimore, Williams and Wilkins, 1973, p 795.
2. Wynne-Davies R, Lloyd-Roberts GC: Arthrogryposis multiplex congenita. *Arch Dis Childh* 51:618-623, 1976.
3. McKusick VA: *Heritable disorders of connective tissue*. 4th Ed, St Louis, CV Mosby, 1972, pp 635-636.
4. DeMyer W, Zeman W, Palmer C: The face predicts the brain: diagnostic significance of median facial anomalies in holoprosencephaly (arhinencephaly). *Pediatrics* 34:256-263, 1963.
5. Duncan PA, Klein RM, Wilmut PL, Shapiro LR: Additional features of the Aarskog syndrome. *Pediatr* 91:769-770, 1977.
6. Segall M, Shapiro LR, Freedom W, Boone JA: XO/XY gonadal dysgenesis and gonadoblastoma in childhood. *Obstet Gynecol* 41:536-541, 1973.
7. Gorlin RJ, Goltz RW: Multiple nevoid basal-cell epithelioma jaw cysts and bifid rib: a syndrome. *NEJM* 262:908-812, 1960.
8. Gorlin RJ, Cervenka J, Pruzansky S: Facial clefting and its syndromes. *Birth Defects* 7(7):3-49, 1971.
9. Whitaker LA, Randall P: The developing field of craniofacial surgery. *Pediatrics* 54:571-577, 1974.

NOTICE

The Resolution listed below will be reintroduced at the House of Delegates Meeting of the Medical Society of Delaware to be held on September 22 at the Delaware Academy of Medicine Building.

Whereas, our present By-laws make it unduly difficult to amend these same By-laws at the regular session of the House of Delegates; and

Whereas, it has become important for the By-laws to be kept current and appropriate to today's needs; now therefore be it

Resolved, that Article XV Section 1 be deleted in its entirety, and the following new Section 1 be adopted in its stead:

ARTICLE XV AMENDMENTS Section 1 PROCEDURE

These By-laws may be amended on the approval of two thirds (2/3) of the members of the House of Delegates present and voting. A proposed amendment shall not be acted on, however, until it has been considered and reported on by the Standing Committee on Constitution and By-laws.

LITIGATION-PRODUCED PAIN, DISEASE AND SUFFERING: AN EXPERIENCE WITH CONGENITAL MALFORMATION LAWSUITS*

ROBERT L. BRENT, M.D., PH.D.

Introduction

The exponential rise in malpractice litigation is due to attitudes and happenings in the medical, legal, and lay sectors of our society. Evaluation of congenital malformation lawsuits provides a unique opportunity to evaluate the process of litigation. Because the cases are rarely meritorious, the litigation process is detrimental to the plaintiff and society and frequently unfair to the defendant. There is no area of our legal system with such a high percentage of innocent defendants. When the family of a malformed infant becomes orchestrated by an attorney into a position of devoting their energy to winning a lawsuit, many high priority family responsibilities may be ignored and important ethical standards distorted.

To win at all costs may be appropriate for a football team, but it can be detrimental to a family. The family enters the litigation arena unaware of the lengthiness of the litigation process and ignorant of the fact that only a small portion of the malpractice premium dollar ever reaches the patient. The plaintiffs are not the only participants who lose their objectivity and lower their ethical standards. The quality and veracity of the testimony of expert witnesses has deteriorated to the point that drastic corrective measures have to be instituted. I believe that recommendations for solving the malpractice

crisis, which are based on the experience with congenital malformation lawsuits, should have applicability to the overall malpractice problem and must involve changes in the medical, legal, and lay sectors of our society. It must be recognized that it is difficult to alter the laws and procedures that are not of benefit to the legal profession because so many legislatures are dominated by elected officials who happen to be attorneys.

See editorial comments on page 233.

Of all the recommendations put forth, the one having the greatest beneficial effect on the present malpractice crisis would be the elimination of the contingency fee system and replacing it with no-fault compensation or legal-fee insurance. The contingency fee system provokes and promotes malpractice litigation. The process of litigation rarely solves the patient's problems and frequently develops into a disease all its own.

The comments which follow are based on familiarity acquired over the past 15 years with over 100 lawsuits and potential suits concerning malformed infants and children. While this is a narrow area of medical negligence litigation, I believe that the lessons learned are generally applicable to the problem of alleged malpractice. Many suits were withdrawn, and some were settled. Approximately 25 went to trial. The increase in malformation suits, which has occurred in recent years, is simply a reflection of the exponential increase in the incidence of general malpractice litigation. In 1967, the paper, "Medicolegal Aspects of Teratology," foretold that increase and made certain recommendations to

Dr. Brent is Chairman, Department of Pediatrics, and Director Stein Research Center, Jefferson Medical College of Thomas Jefferson University.

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Dr. Brent reported on this subject at the Wilmington Medical Center May 11, 1977, Wilmington, Delaware.

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reduce or eliminate unwarranted litigation in the area of congenital malformations.¹ These recommendations, the adoption of which is now urgent, will be repeated at the end of this paper. On the basis of new experience since the 1967 publication, it is now my thesis that the process of medical malpractice negligence litigation is, itself, often so deleterious to the plaintiff that even a "successful" outcome rarely benefits him or the injured child in whose name the suit is brought. The litigation process is enervating for the family. Case histories show that when a family become orchestrated by a lawyer into devoting much of their energies into the litigation process, many high priority family responsibilities are ignored, and important cultural standards are distorted. To win at all costs may never be good; it is surely bad for a family.

The following case histories illustrated this thesis:

Case History 1

A woman in her mid-thirties had been visiting a fertility expert in order to conceive. She had several

previous children and one abortion at three months gestation. She had not been able to conceive for the past several years was receiving triiodothyronine daily and was recording her temperature daily. On the 25th of the month, she noted a temperature rise and had intercourse on the 25th and 26th, which were the only times she had intercourse that month. Two days later she sustained a serious fall. In the process of evaluating the injuries, a series of roentgenograms was obtained on the fourth and fifth day of pregnancy. The total maximum dose to the embryo was 1.8 R. During the remainder of the pregnancy, the patient was treated for her back injuries and for other problems. The medications included propoxyphene (*Darvon*, Lilly), codeine, triclothyromine (*Cytomel*, Smith Kline and French), chlorpheniramine maleate, stilbesterol, vitamins K and C, and various sedatives. Near term a baby with Beckwith's syndrome was delivered by Cesarian section. I was called as a consultant to determine whether the x-irradiation could have produced these anomalies. This consultation report was submitted to the plaintiff's attorney. My report indicated that the dose of radiation was too low to produce malformations at any stage of pregnancy and, furthermore, the embryonic age at the time of the accident and at the time of radiation exposure occurred during the period when the mammalian embryo is insensitive to the teratogenic effects of radiation. The plaintiff's attorney called me and requested that the report be altered. I refused and had no further communications from that attorney. The mother of the malformed child was a bright, well-bred individual from the upper-middle socio-economic strata who became very interested in the causes of malformations. She visited my office, and I discussed this subject with her.

Approximately six years after the birth of this baby, I received a subpoena at five o'clock one afternoon ordering me to appear in court the next morning. The defense attorney had obtained from the hospital chart my original consultation in this case and was puzzled by the fact that I had not been called as a plaintiff's witness. In this rare instance, both the plaintiff and defense attorneys considered me a hostile or non-supportive witness. When I entered the courtroom, the plaintiff's mother turned pale as did the plaintiff's attorney. I sensed a tremendous amount of anger and resentment as the plaintiff's attorney initiated his questions. Issues and facts were ignored, and the main approach of the plaintiff's attorney was to indicate that I was a "professional" witness (although this was my first appearance in court) and that I was in collusion with the defense attorney (an individual whom I had never seen or heard of before that morning. The countenance of the mother and the demeanor of the plaintiff's attorney became understandable when it was revealed that the mother of the plaintiff had altered her story by changing the dates so that the

embryo would have been three weeks old at the time of the radiation exposure, a stage that would be susceptible to teratogenesis. Alteration of data and suppression of the original expert testimony undoubtedly played a significant part in the loss of the suit by the plaintiff.

Comment

Preparation for the litigation and the trial itself occupied seven years of this family's time and energy. It is not uncommon for the enthusiasm of the attorney to be interpreted by the plaintiff to mean that the case is so meritorious that he or she deserves to win by any means. It is likely that the attorney and the mother knew that they were changing important data in order to make a better case. They were able to support each other's behavior because the child's malformations were real and they believed that someone in this society must be responsible for the occurrence of the malformation. Because of the lack of medical, psychological, and social supports in our society, it is easier for a family to project their anger and frustration on someone rather than bear their burdens with equanimity. The lawyer frequently aids and abets this process. The story does not end here, because this mother was firmly convinced that her infant was malformed by something related directly or indirectly to her original accident. Although the court, the attorneys, and the other witnesses could forget the litigation and go about their business, the plaintiff's mother was convinced that an injustice had been done, and her anger and anguish remained unresolved. On several occasions many months later, she verbally accosted me in public places at which time she displayed quite bizarre behavior.

Case History 2

During the eleventh week of pregnancy, an expectant mother was sitting in the rear seat of an automobile which was hit broadside by another. Her car overturned, and she sustained a comminuted fracture of the right femur. There was no obvious injury to the abdomen, no abdominal pain or tenderness, and no vaginal bleeding. Examination by her obstetrician over the next ten days revealed all aspects of the pregnancy to be normal. She was eating well in the hospital. Members of the family suggested that she obtain an attorney following her discharge from the first hospital 11 weeks after the accident.

A well-known negligence attorney was retained, who discharged the expectant mother's physician and selected another physician. This physician, an obstetrician, examined the patient for the first time in the twenty-ninth week of pregnancy and admitted her to another hospital for the remainder of the pregnancy because "she appeared markedly undernourished" and the patient complained of a ten-pound weight loss.

During the first and second hospitalization all the records indicated that the fetal heart rate and movements were normal. During the thirty-eighth week of pregnancy she delivered the plaintiff. During the course of her labor, her blood pressure dropped precipitously, and the fetal heart rate dropped simultaneously. With the infant in an arrested transverse position, vasopressors and pitocin were administered to the mother while a mid-forceps delivery was attempted. The transverse position was converted by fundal pressure, and the infant was delivered 35 minutes after the maternal blood pressure dropped. The umbilical cord was within the birth canal during the second stage of labor and was compressed by the infant's neck and shoulder. At birth the infant was deeply cyanotic, and did not breathe for two minutes nor cry for 45 minutes. There was absence of muscle tone and failure to respond to painful stimuli, and convulsions occurred on the second day of life.

At the time of the trial the child was a little girl approximately nine years old with severe spastic quadriplegia. The negligence attorney's obstetrician testified that in his opinion the cerebral palsy was due to the automobile accident in the eleventh week of pregnancy which resulted in damage to the placenta. He also testified that the placenta was 70-80% infarcted at birth and that these infarctions were due to the trauma of the automobile accident. An authority in cerebral palsy and an embryologist and pediatric rehabilitationist both testified that in their opinion the automobile accident produced the placental infarctions and the resulting cerebral palsy.

My testimony was as follows: The work of Windle and Meyers clearly indicates that the lesions of cerebral palsy are produced in the perinatal period and not during the first trimester. There were at least four obstetrical mishaps in this case which are etiologically correlated with perinatal brain injury. If the placenta was infarcted 70-80% by the accident in the eleventh week, it would be impossible for the fetus to reach almost seven pounds at the thirty-eighth week. One would expect severe growth retardation if the placenta actually was 70-80% infarcted, and, in fact, the embryo probably would not survive. There is no clinical or experimental data to indicate that environmental insults in the first trimester result in brain lesions that are observed in cerebral palsy. Although the plaintiff's mother had been awarded damages to herself for

her personal injuries, the jury did not conclude that the automobile accident contributed to the plaintiff's cerebral palsy.

Comment

Once this mother retained a negligence attorney, her entire approach to this pregnancy changed. While the original obstetrician could find nothing objectively wrong with this pregnancy, she retrospectively complained of abdominal cramps and vaginal spotting. Her recorded weight gain was better than her previous pregnancies, but she complained about weight loss. Her visit with the attorney-appointed obstetrician resulted in readmission to another hospital for the remaining two months of her pregnancy. This admission was only to make the plaintiff's case more impressive. The mother did not consciously change her priorities, but this pregnancy and her family responsibilities, in fact, became secondary to the goal of winning a legal battle.

What prompts an individual to discharge her family obstetrician and allow herself to be readmitted to a hospital many miles from her home and family, in spite of the fact that she is well? What prompts physicians and scientists to testify for the plaintiff or defense when the data they are presenting is unsound and sometimes untrue? Why does a patient permit an attorney to direct his medical care in medico-legal cases? There is the driving interest in the monetary reward for those participating in the process, be they plaintiff, attorney, or expert witness. For the patient, it may be misdirected anger and revenge. For the expert witness, it may be the ego gratification of being called an expert. For the at-

torney, it is the error in thinking that winning the case will solve the patient's or plaintiff's problems. It may make the problem worse. If anyone contributed to the occurrence of cerebral palsy in the plaintiff, it was the plaintiff's attorney, the second obstetrician, and the medical profession and state licensing laws that permitted the second obstetrician to practice medicine.

Case History 3

A mother who had recently immigrated to the United States and spoke no English delivered a child with phocomelia. She had been given an antibiotic for an upper respiratory infection by her obstetrician in the latter part of the third trimester. The family on behalf of the plaintiff sued a large pharmaceutical firm indicating that the antibiotic had produced the malformations. Pre-trial briefs were presented to the court. The defense presented experimental and epidemiological data that indicated that the antibiotic did not cause this child's malformations. The plaintiffs could not find an expert witness to support their claim. They did, however, present data which indicated that high doses of this antibiotic could interfere with mouse embryonic development and there were several isolated case reports of malformations in infants whose mothers took the antibiotic plus other drugs. The court ruled that there was not enough evidence to warrant a trial, and the case was dismissed. The mother of the malformed infant was distraught, displaying hysterical antics following the court's ruling. The plaintiff's attorney did not abandon the case, however. After two years of searching, the attorney found a general practitioner in a small town who was willing to testify on behalf of the plaintiff as an expert witness. The brief to reopen the case was identical to the original complaint, but now it had the authenticity of an "expert" witness. The case reopened and went to trial.

Comment

None is needed.



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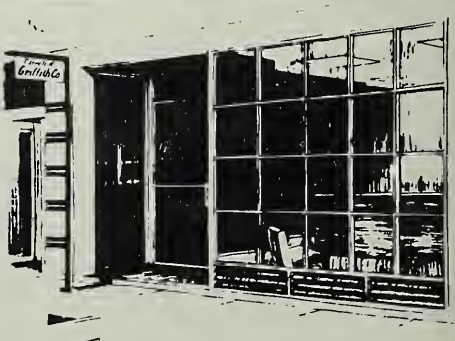
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TABLE 1
DISTORTION OF THE FACTS BY PARTICIPANTS IN MEDICAL NEGLIGENCE LITIGATIONS

	Plaintiffs	Plaintiffs' Attorneys	Plaintiffs' experts	Defendants	Defendants' attorneys	Defendants' experts
Number	17/	19/	19/	6/	1/	2/
Total cases	17	23	31	24	21	27
Percent	100	82.6	61.2	25.0	4.7	7.4

These figures were obtained by reviewing the depositions and trial minutes in each case. The occurrence of distortion of data was recorded only when it was very obvious.

Discussion

The incidence of medical malpractice litigation has passed epidemic proportions²⁻⁷ with a possible future malpractice rate per physician of greater than 10% per year and premiums running into billions of dollars.³ Numerous changes in the present system have been suggested, including the possibility of "no fault" malpractice insurance.^{2,3,6,8} Utilizing a judicial process to solve malpractice disputes has been called an "archaic social tool" unfit for present day medico-legal problems.⁷ This statement is supported by the fact that 85% of malpractice premiums are accounted for by defense and plaintiff lawyers' fees and insurance companies' administrative costs.

The case histories presented in this paper emphasize that there is a dimension beyond the legal and financial aspects of malpractice litigation. The social and psychological aberrations demonstrated by lawyers, patients, and physicians in these three cases were present to a greater or lesser degree in almost all the 100 cases with which I have been involved and in every single one that went to trial. In these cases, it was rare that a family benefitted from the litigation process. Most families would have suffered less and resolved their problems sooner had they not engaged in litigation.

Contributing Factors and Possible Solutions to the Malpractice Epidemic

Some of the following comments and recommendations relate only to the problem of litigation involving malformed infants, but many apply to malpractice in general. A unique aspect of litigation involving malformed infants is that the alleged malforming agent, or drug, is rarely re-

sponsible for the infants' malformations or embryopathology.⁹⁻¹³ The fact that hundreds of lawsuits have been initiated in this area may provide some insight into the magnitude of the litigation epidemic. *The patient, the physician, the attorney, and the legal and health care systems* all are contributing forces to the malpractice epidemic.

The Patient as a Plaintiff

Most families that become involved in litigation concerning the causation of malformations in their child do not realize how long the litigation will last. Nor are they aware of the energy and time that will be involved—for all parties. Yet, these are minor problems compared to what else happens to the patient or the family.

In few other circumstances would a patient solicit an attorney's advice in selecting a physician. The plaintiff is ready and willing to have his medical problem managed by his attorney. First, the patient abandons his regular physician. Then he will visit physicians, therapists, photographers, and psychologists, in spite of the fact that it is perfectly obvious that the main goal of the attorney's medical consultants is to win a legal case and not to provide excellent medical care. The patient knows that the visits are more frequent than is necessary and that the interaction between the doctor and the patient is a charade.

The family of a malformed child frequently interprets the malformation as a stigma. The associated shame and guilt are sometimes projected outside the family.^{9-11,14} The physician, place of employment, or pharmaceutical firm may become a convenient scapegoat. Thus, the liti-

gation process may be one method of projecting blame for a congenital malformation outside the family unit.

Litigation may also be a mechanism for expressing anger. Drotar et al studied the adaptation of parents to the birth of a child with congenital malformations.¹⁴ The authors found that these families had a predictable course of parental reactions which included *shock, denial, sadness, anger, adaptation, and reorganization*. They advise early intervention with professional help to assist the family through the painful stages so that the family may become reorganized as soon as possible.

Litigation prolongs and amplifies the family's anger. Its initiation aborts the process of reorganization. Since the litigation process may last for years, we frequently observe an "anger fixation" that modifies the personality of the family beyond recognition. The attorney's role in this process is interesting and will be discussed later.

When families or individuals psychologically decompensate under the stress of prolonged litigation, it is difficult to determine whether the litigation process or the individual's basic personality was the more important factor. We do know that the pathological pursuit of the resolution of problems via litigation is clinical evidence of psychological decompensation.¹⁵ Although it is difficult to obtain objective data, it appears that the guilt feelings,^{16,17} remorse, and depression are also prolonged by the litigation process. Even more important, the resolution of the legal problem exacerbates many of the early reactions which should have been resolved long ago.¹⁸

Lying and distortion of facts are common occurrences in medical negligence suits. (Table 1) In Case 1, the mother changed the dates of her LMP so that the embryo was in a more susceptible period. In case 2, the mother complained of cramps, bleeding, and weight loss, although there was never any objective evidence of these findings and, furthermore, the symptoms and signs occurred only after the mother retained an attorney. In Case 3, the mother admitted to taking only the suspected drug during her pregnancy, no other medications. It is interesting that the average mother either takes or is adminis-

tered 11 medications during pregnancy, unless she is involved in litigation. Mothers involved in litigation rarely remember taking anything during their pregnancy except the suspected drug.

Why are the facts so frequently distorted in malformation cases? First of all, the plaintiff's case is frequently very weak, yet the plaintiffs are usually convinced they are in the right. If they are right, then the defendant has wronged them. To win the case would confirm their position. Distortion of the data seems an appropriate method of guaranteeing that the defendant is punished. The plaintiff's attorney is an active but silent partner in the process, since the attorney's primary goal is to win the case.

The consequences of the litigation process are rarely considered by the plaintiff or the attorney. If the family has altered its moral behavior in order to win a lawsuit, the family could be seriously affected long after the litigation is complete. During the litigation process, the home, the other children, and one's profession or job may be neglected, since most individuals do not realize the length of the litigation process and, therefore, do not understand the extent of their original commitment. The psychological liability of being in a perpetual state of belligerency cannot be measured. The moral and social liabilities are rarely measured against the financial rewards of litigation, and when these intangibles are not considered by either the plaintiffs or their attorney, the scale tips heavily toward litigation.

The Defendant

In these United States, it has always been psychologically easy, although difficult in practice, to sue "impersonal" corporate bodies and government agencies. The assumption by the public is that the malpractice award is "no one's" money and it "doesn't hurt anyone." Furthermore, the public in general has a continuing hostility toward large corporations and governmental agencies for both rational and irrational reasons. Unfortunately, it has become easier to sue the physician as his image has changed from that of a caring family doctor. Although the medical profession still has the respect of the lay community, it no longer has the patient's affection.

Caustic and sarcastic comments about physicians have been recorded for years.

"With the exception of lawyers, there is no profession which considers itself above the law so widely as the medical profession."¹⁹

"Doctors are just the same as lawyers, the only difference is that lawyers merely rob you, whereas doctors rob and kill you."²⁰

The vindictiveness of the preceding quotations from the past differ from the present climate only in quantity, not quality. In a recent discourse Hardy elaborated on the materialistic image of the physician.²¹ She used such phrases as, "He has a cash register mind." "Are you planning to be a two-Cadillac ambitious doctor?" "He must have killed a great many people to get so rich." Those physicians who charge reasonable fees, live modestly, and are dedicated to delivering quality care are obviously having little impact on the physician's public image. When I recently visited several retirement communities in south-

ern Florida, I was overwhelmed by the animosity of the aged population to impersonal service and exorbitant fees.

In the past, physicians generally could become wealthy only by participating in financial matters outside the field of medicine. Today, the manipulation and, in some instances, the exploitation of third party payers have enabled some physicians to become rich directly from the practice of medicine. Furthermore, in the past, physicians provided a significant amount of free medical care. The third party payer system and the higher costs of running a medical practice have practically eliminated these charitable services. Thus, the doctor, once seen as considerate and generous, has, for many, metamorphosed into a materialistic business man.

Although most patients do not consider physicians to be malpractitioners or incompetent, there has been an increase in the notoriety given to the

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notion that physicians do commit a great deal more malpractice than is revealed. Furthermore, there is data to indicate that many physicians are aware of instances of malpractice, dyspractice, or incompetence, but are unwilling to report them to the local medical society or the licensing agency of the state.²² The widening knowledge of these instances, together with the doctor's new materialistic image, psychologically tips the scale toward litigation.

The Physician Expert Witness

It is alleged that malpractice litigation was uncommon years ago because attorneys were unable to obtain expert medical witnesses to testify against other physicians.^{23,24} The allegation is probably partially correct. Today, the expert medical witness for the plaintiff is no longer a rarity. Robitscher describes the plaintiff's expert medical witness as follows: "... a small fraction of medicine that relishes the attention and sometimes also welcomes the remuneration that results from court testimony ... who is ready to see causal connections—a blow by a taxi door and the resulting development of cancer ... Lawyers use these witnesses frequently, but they do not always respect them." They are a "few of the best doctors and most of the worst doctors."²⁵

Since not all litigation involving malformed infants involves a physician-defendant, it has been somewhat easier for the plaintiff's attorney to obtain an expert witness, especially if the defendant is a pharmaceutical firm, industrial firm, or branch of government. My experience in malpractice litigation is limited to areas of radiation hazards and the etiology of malformations, but in these cases I have been amazed at the lack of veracity and objectivity of many plaintiff's expert witnesses. (Table 1) As an example, a scientist who published a paper in which he listed a drug as non-teratogenic was willing to testify for the plaintiff when the same drug was implicated as a cause of a child's malformations. In Case 3 presented in this paper, an unfounded lawsuit which had been discontinued was reinitiated when the plaintiff's attorney was able to locate a general practitioner to testify as a medical expert witness in the field of teratology. The medical expert who testifies for the plaintiff usually demands and receives substantial fees

resulting in a sycophantic alliance between the expert witness and the plaintiff's attorney.

The expert witness could measurably improve the malpractice situation by being more critical of his/her role as an expert witness. Some expert witnesses assume the role of a partisan. It is an untenable position for an expert medical witness if he—

"automatically sorts the facts newly brought to light. He retains those, even the modest ones that seem to prove him right and neglects the others, even the clearest and most precise and convincing ones if they appear to indict him. Blinded by his passion, that is, by his immoderate love for his theory, he has recourse to all means, honorable or not, in order to defend it, for to him all means have become legitimate. He has ceased to be a scientist and has become a partisan."²⁵

In the past, expert witnesses did not testify on a contingency fee basis because it might distort the objectivity of the expert witness. At the present time there is a suggestion in some legal circles to allow expert witnesses to be paid on a contingency fee basis. If this came about, it would exponentially increase the incidence of partisan expert witnesses and destroy the credibility of all expert witnesses.

The Plaintiff's Attorney

The evils of malpractice litigation are related more to the litigation process than to any sinister qualities of the plaintiff's attorney. In most instances, the attorney is a bright, energetic individual who is utilizing the legal system to obtain compensation for his injured client. Although the plaintiff's attorney admits freely that the tort system has many disadvantages for the client, he believes that society has not provided a better means to solve the injured client's dilemma. Furthermore, the legal profession has no incentive and little inclination to provide a better method of compensating injured victims.

There are a number of abuses practiced by attorneys that contribute to the increasing incidence of malpractice and negligence litigation. *Attorneys are presently actively seeking malpractice cases.* Informants have been placed in hospital record rooms by law firms engaged in negligence law. Ambulance chasing appears to be on the increase. At a post-graduate seminar in

Wellsboro, Pennsylvania, I was told by one of the family physicians that a patient of his received a telephone call from a large Philadelphia law firm. The patient had just returned from an eye hospital in Philadelphia following surgery for a retinal detachment. The law firm wanted to know whether "everything was all right." This is a sophisticated approach, because the attorney had enough medical knowledge to select a disease category in which it was unlikely that everything would be all right.

In the area of human malformations, the physician or pharmaceutical firm is extremely vulnerable to the plaintiff's attorney who actively solicits business. As an example, one percent of the three million annual pregnancies have some exposure to diagnostic radiation. Four percent or 120,000 of these pregnancies will result in some type of congenital abnormality which is unrelated to the radiation. Therefore, by chance alone there are 1,200 malformed infants born each year to mothers who received diagnostic x-ray exposure. The potential number of lawsuits involving malformed infants is staggering.

Attorneys are also willing to accept a malformation case that has no merit because of the possibility of obtaining a small out-of-court settlement. The cost of the legal process has become so expensive that insurance companies are sometimes inclined to settle non-meritorious lawsuits for several thousand dollars. In most instances, the defendant is not sympathetic to the insurance company's willingness to settle. These numerous small claims and settlements have been one cause for the increase in malpractice premiums and are of minimal benefit to the injured patient, or to society as a whole, but do provide some income for the negligence attorney.

Even more ominous than the settlement of non-meritorious nuisance claims for small amounts of money is the settlement of non-meritorious suits by large corporations in an effort to avoid publicity. In the past three years, two very large suits were settled out of court because the manner in which the plaintiff was dealt with by a physician or supervisor was less than optimal. In one instance, a physician did not realize a patient was pregnant and did an exploratory laparotomy. In the other instance, a pregnant woman

working with a very "safe" piece of x-ray equipment was refused permission to be transferred during her pregnancy. Although the resulting malformations were unrelated to the plaintiff's accusations, the cases were settled to avoid bad publicity. The plaintiff's attorneys used the "double jeopardy" concept prevalent in congenital malformation lawsuits in order to blackmail the defendants into submission.⁹ This turn of events is very ominous and will measurably worsen the already serious epidemic of negligence and malpractice lawsuits.

The pursuit of non-meritorious lawsuits by attorneys may even continue after several expert witnesses have rendered an opinion contrary to the attorney's wishes. In several instances the attorneys have requested that I alter my expert opinion in order to strengthen their position enough to obtain an out-of-court settlement. (Table 1) Let me quote from an attorney's letter.

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The plaintiff's attorney is frequently insensitive to the impact of the litigation process on the family. There is no evaluation of a family's stability or suitability to enter the litigation arena. Just as there are people who are psychologically unsuited to drink, gamble, or play the stock market without damage to themselves, there are families who suffer immensely from the strain of the litigation process. *I have never seen a family counseled to avoid litigation because it may be hazardous to their health.* Since the true pursuit of justice often plays no part in initiating malpractice suits, and since most malformation lawsuits have no merit, the plaintiffs may be trapped into litigation only to provide fodder for the litigation process. How many would be spared if they heeded Edmund Burke's wise counsel—"It is not what a lawyer tells me I may do: but what humanity, reason and justice tells me I ought to do."²⁶ This admonition from long ago remains largely unheeded by the public.

One must not be too critical of the lawyer since "lawyers are trained to win cases rather than solve problems,"²⁷ while some recognize that society and the plaintiff would benefit from less costly ways of shifting burdens. It is unlikely that alternative methods for solving the plaintiff's problems will come from the legal profession, since they have a vested interest in preserving the tort system and control most of the legislative bodies in this country.

The Medical Care and Legal Systems

If all medical care, rehabilitation, custodial care, and social-psychological services were freely available to everyone, the frequency of malpractice lawsuits would, of course, be drastically reduced. Since we are a long way from that extreme of socialized medicine, we must

recognize that the fragmentation and the high cost of medical care are contributing factors in malpractice litigation. Just as patients may become angry at the physicians, so have they become angry at many aspects of the health care system.

The most controversial aspect of this entire topic deals with the appropriateness of utilizing litigation for compensating injured patients. Some competent individuals are firmly convinced that the legal system is a satisfactory mechanism for compensating injured patients.²³

"It is in the legal arena, more than any other part of our society, where medicine can be made aware of its lack of certainty . . .

"It seems to me that the adversary system is the honest way of exposing the truth . . .

"Civilization has yet to produce a better system of adjudicating the differences between man and man and institution, than the Anglo-Saxon administration of law."²³

My experience in malpractice litigation leads me to disagree vehemently with the concept that litigation is a proper and suitable means of solving an injured patient's problem. Justice is an accidental by-product of the litigation process. What has been most disconcerting to me is that, in many cases that were deservedly lost, the plaintiff's attorney could have been provided with an approach that may have reversed the results of litigation, in spite of the fact that malpractice had not been committed. Should a plaintiff's future or a defendant's reputation depend on a game of skill between opposing attorneys and expert witnesses?

Rubsamen says, "the jury system is basically irrational."²⁴ Wiseman sums up the frustrations of the litigation process as follows:

"The assertion that society must accept the tort system as the only available solution for the problem of medical malpractice is obviously not valid. It is the last desperate argument of legal chauvinism. Social engineering has advanced to a point where the public is no longer restricted to the crude choices of frontier days.

"The tort system in medicine was designed, created, and administered by lawyers; it is not criticism of law as a profession but a general commentary on human nature to observe that it now benefits no one but lawyers. It hurts everyone else . . .

"The tort system can no more be reformed to fit modern medical requirements than could a dinosaur be made into a creature suited to the present. The tort system belongs to the history books like covered wagons and knights in armor. The facts speak for themselves; *res ipsa loquitur*."7

The worst aspect of the tort system is the contingency fee basis for funding litigation. Directly or indirectly, it has become a significant cost of medical care. The defenders of the contingency fee claim to be convinced that it permits the poor to recover damages, something which could be accomplished equally well with some kind of legal insurance. Actually, the contingency fee not only allows the poor to sue, but it also stimulates litigation from all economic classes. Countries without a contingency fee have few malpractice lawsuits.^{4,24}

"Without a contingent fee system, malpractice litigation unquestionably would be dormant in the United States. The likelihood of recovery in many substantial meritorious cases is sufficiently equivocal to forestall litigation unless the plaintiff's attorney can look for a high return in the case of a win. So the plaintiff's bar seems to have the better part of the argument in retaining the contingent fee. But the fact remains, that the scale of recovery under our contingent fee system is almost totally irrational."²⁴

The quotation by Rubsamen defends the contingency fee because it provides a mechanism for a meritorious client to recover damages. Rubsamen would modify the fee structure so that the awards were more appropriate and the attorney's remuneration was lower. Thus, Rubsamen defends the contingency fee in the name of justice. But the majority of malpractice suits prove to be without merit, and the contingent fee system stimulates malpractice lawsuits. Is it not injustice to accuse and malign a very large number of non-negligent defendants? It is apparent that much "malpractice" is truly "dyspractice."⁸ Reichman, in discussing quality medical care, stated "A satisfactory outcome is never guaranteed for the patient, even when the process of care is excellent."²⁸ Therefore, "the allegation that a physician is a malpractitioner . . . is not necessarily an accusation that he is inept."²⁹ This indicates that physicians and other potential defendants are expected to assume the burden of negative results that may not be associated with malpractice. It is this new concept

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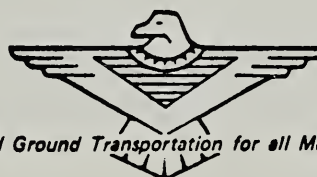
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of unrealistic expectations in malpractice and medical negligence litigation that has exponentially increased the number of lawsuits. In malpractice law, what may be "justice" to the plaintiff may be "injustice" to the defendant and vice versa.

Epilogue

Many recommendations for changing the litigation process have been presented in the appendix. These recommendations have been made in the belief that it will literally be impossible to eliminate the litigation process as the method of settling malpractice claims. But, I wish to emphasize that in the long run, I believe, the greatest benefit to all would come from elimination of the contingency fee and replacing it with either no-fault medical insurance or comprehensive law insurance. There would be an immediate reduction in the frequency of non-meritorious negligence litigation. Society would then be forced to utilize other means to solve problems which had been left in the inefficient and unjust hands of the litigation process.

The elimination of the litigation process is nothing other than "good medicine." When a physician observes that a drug harms more patients than it helps, he stops using the drug. It is easy to observe that the litigation process is very bad for the patient and for most others who are involved in the process.

I have learned from past experience that the analysis and criticism of a problem in a scientific journal does not solve problems.^{1,9-11} However, it is a useful first step in pointing out that the problem exists and solutions are available. The next step must follow. Those who believe that the contingency fee and malpractice litigation are archaic social tools will have to enter the political arena or convince those who are there that these matters should have a high priority.

Summary

In 1967, I indicated that the number of lawsuits involving malformed infants seemed to be increasing, not realizing that the increase was foretelling an epidemic. The reasons for this epidemic are described in this paper and are due to attitudes and happenings in the medical, legal,

and lay sectors of our society. Case histories have been utilized to demonstrate that the litigation process can produce pain and suffering and, in some instances, even disease. The case histories also indicate that, when a family becomes orchestrated by a lawyer into the position of devoting a great deal of their energy to litigation, many high priority family responsibilities are ignored and important ethical standards are distorted. To win at all costs may be good for a football team, but it is obviously bad for a family. We must make drastic changes in the method of supporting the victims of disease and injury so that litigation is no longer necessary to compensate and support patients and families whether negligence is or is not a factor.

Recommendations for diminishing the malpractice crises include: (1) education of the patient about the consequences of the litigation process—the fact that only a small portion of the malpractice premium dollar ever reaches the patient and the fact that most human malformations are not produced by medical negligence; (2) altering the deteriorating physician image, reversing the increase in irresponsible medical expert testimony, and changing the laws pertaining to medical licensure and loss of medical licensure; (3) improving the health care system; (4) making the awards more realistic by taking into consideration community and insurance resources of the patient and by eliminating lump sum awards and "punitive" awards; (5) decreasing lawyer representation in legislative bodies so that legal reforms will become a possibility; and (6) eliminating the contingency fee system by replacing it either with legal insurance so that the attorney is working for the patient or by adopting no-fault malpractice insurance with binding arbitration so that the negligently injured patient is properly compensated. The process of litigation rarely solves the patient's problems and frequently develops into a disease all its own.

APPENDIX

Recommendations

Recommendations made in 1967^{1,9-11} in order to decrease the number of non-meritorious congenital malformation lawsuits: (1) Establishment of authoritative sources of information to assist the court,

such as a national committee of authorities that could render an unbiased scientific opinion about the merits of a malformation case as a friend of the court; (2) Introduction of the concept of a medico-legal workup. In many instances, a preliminary evaluation which includes a genetic history, amino acid analysis, cytogenetic study, and documentation of the defect can indicate that the particular case does or does not have merits. If the courts required such a basic workup before litigation could be initiated, many cases would never come to trial; (3) Creation of new laws to define responsibility and the rights of fetus, parent, physician, and pharmaceutical firm or other industries; (4) Teaching physicians and industrial corporations the art and sciences of proper communication.

The public should be educated to the fact that few congenital malformations are caused by drugs and radiation. The plaintiff should also be made aware of the length of the litigation process; the disorganizing and enervating effect that litigation can have on a family; and the fact that in nuisance settlements the attorney's fees and expenses consume most of the award. The patients should also be aware of the fact that the litigation process, which is supposedly for their benefit, delivers only 15% of the billions of dollars of malpractice premiums to the injured party. The lawyer's own medical team is more interested in assisting in litigation preparation than in treating the patient. Therefore, only under unusual circumstances should the patients abandon their usual physician.

The materialistic image of the physician has taken some time to develop. It is very likely that it will remain with us until national health insurance becomes a reality or there are drastic changes in the methods of reimbursing physicians and delivering health care.

It may be possible to drastically alter the contribution of unscrupulous expert medical witnesses to malpractice cases by making their testimony available to their hospital staff or their academic department chairman. Professional witnesses rarely announce their participation in lawsuits. When confronted with the knowledge that they had participated in a lawsuit as an expert witness, they will deny it or claim that they took a very peripheral role. Physicians would be amazed at the number and position of their colleagues who have become plaintiff expert witnesses. I suggest that medical societies require their members to file reports or at least report their participation in litigation as part of the requirement to remain in the medical society. I believe that some mechanism shedding the light of day on expert testimony would go a long way in increasing the responsibility and accuracy of this testimony.

It is necessary to educate medical students and

physicians about the proper role of an expert medical witness as well as to the fact that this role has been distorted by the lure of money and reputation.³⁰

If attorneys could honestly evaluate the burdens and benefits of the present malpractice crisis, they would support drastic changes in the methods of compensating the injured. The problem is, as the previous paragraphs have indicated, they have vested interest in maintaining the status quo. We, therefore, must recognize that we cannot expect major reforms to emanate from the legal profession.

Litigation would be reduced if the health care system provided acute, intermediate, and chronic care for injured patients. A medical-social welfare system that provides total care would eliminate the necessity for the exorbitant awards and, in many instances, the necessity for litigation. At the present time, a total social-medical welfare program is not on the horizon.

The size and appropriateness of compensation awarded by the court would be more realistic if all the resources available to an injured party were known to the judge and jury. It seems ridiculous to ignore already paid-for-medical care programs provided by the government or insurance system. Furthermore, the lump-sum award is also fiscally irresponsible, since it frequently benefits the relatives and estate of the injured patient rather than the patient. The cost of total awards would diminish if an appropriate award could be paid monthly or quarterly for the duration of the patient's life. There are many instances wherein a patient received a large financial award and died within the year. This type of an award distorts the purpose of the litigation process and primarily serves the needs of the attorney whose fees are based on a contingency fee.

This brings us to the most controversial topic of all and that is the contingency fee. I believe that the patient would be better off in the long run if there were no contingency fee. It would decrease the incidence of negligence lawsuits drastically. It might force the health care system to provide total care for the injured patients. It might even decrease the incidence of malpractice occurrence by forcing the licensing agencies to modernize the process whereby medical licenses are granted and revoked. At the present time, the loss of a malpractice suit is the only form of formal punishment the physician or defendant receives. It is much too severe a punishment for the dyspractitioner and frequently too mild for the malpractitioner.

It is obvious that the legal profession will resist the elimination of the contingency fee with all the resources at its command. Furthermore, it is very likely that it will prevail, since attorneys maintain a majority in legislative bodies in these United States. Probably one of the greatest benefits that might result from the malpractice crisis is the recog-

dition by the public that the legal profession is too highly represented in legislative bodies to permit any reforms that relate to the legal profession. We have been concerned about the racial and sexual representation in jobs and schools. We might begin to look at professional monopolies. All aspects of the democratic process might benefit if no vested interest group (including lawyers) were in control of our legislative bodies. This will evolve only if more non-lawyers enter politics and the electorate recognizes the benefit of decreasing the number of lawyers in legislative bodies.

The contingency fee system increases the total cost of legal services and discourages people from utilizing needed legal services that must be paid. While a middle class or lower socioeconomic class individual might be willing to sue on a contingency basis, he is unlikely to utilize legal services for other important activities. Thus, the promotion of law insurance for all legal services, including malpractice, might be the best containment for litigation costs and place the client in a better position to utilize all legal services appropriately.

A second alternative to law insurance would be no-fault medical malpractice insurance. It would eliminate the necessity for a contingency fee, and the litigation process. Compulsory arbitration by a representative panel would guarantee that most of the malpractice insurance premiums would end up in the rightful hands of the injured patient rather than in legal fees and litigation costs.

At the present time, the medical profession is accused of permitting malpractitioners to continue to practice.²² If this is the case, then it is up to the legislative bodies to alter the laws pertaining to medical licensure so that malpractitioners can have their licenses revoked. In the present situation, a physician who is aware of an instance of malpractice is placed in a serious dilemma. As an informant, he enjoys no protection against civil libel suit by the accused physician. He could be consumed in a legal process which could be costly and enervating.

REFERENCES

1. Brent RL: Medicolegal aspects of teratology. *J Pediatr* 71:288-298, 1967.
2. Ragan CA: Pros and cons of "no-fault" malpractice insurance. *Res and Staff Phys* 19:31-32, 1973.
3. Brierly C, McDonald J, Giacalone J et al: Malpractice in focus. A national problem the states must solve. AMA source document, p 32, Chicago, Prism, 1975.
4. Geekie DA: The crisis in medical malpractice: will it spread to Canada? *CMAJ* 113:327-334, 1975.
5. Schwartz H: Will malpractice socialize United States medicine? *Med Economics* 52:114, 1975.
6. Weech CE: Medical malpractice. *NEJM* 292:1372-1376, 1975.
7. Wiseman LW: Res ipsa loquitur. *West J Med* 123:71-75, 1975.
8. Krugman RD: Immunization "dyspractice": the need for "no-fault" insurance. *Pediatr* 56:159-160, 1975.
9. Bloew RS, Sinclair JC, Warshaw JB: Medicolegal aspects of teratology, in *Biologic and Clinical Aspects of Malformations*. Mead Johnson Symposium on Perinatal and Developmental Medicine No. 7, Vail, Colorado, pp 65-76, June 8-12, 1975.
10. Contributions of experimental teratology to clinical medicine, in *Biologic and Clinical Aspects of Malformations*. Mead Johnson Symposium on Perinatal and Developmental Medicine, No 7, Vail, Colorado, pp 54-64, June 8-12, 1975.
11. Brent RL, Harris M, eds: Environmental factors, Miscellaneous, in *Prevention of Embryonic, Fetal and Perinatal Disease*. DHEW Publication No (NIH) 76-853, 3:211-218, 1976.
12. Wilson JG: *Environmental and Birth Defects*. New York, Academic Press, 1973.
13. Holmes LB: 1976 Congenital malformation incidence: racial differences, recognized etiologies in *Biologic and Clinical Aspects of Malformations*. Mead Johnson Symposium on Perinatal and Developmental Medicine, No 7, Vail, Colorado, pp 3-9, June 8-12, 1975.
14. Drotar D, Baskiewicz BA, Irvin N et al: The adaptation of parents to the birth of an infant with a congenital malformation: a hypothetical model. *Pediatr* 56:710-711.
15. Polsky S: Psycholegalities of everyday medical practice. *Modern Med* 6:82-85, 1969.
16. Solnit AJ, Stark MH: Mourning and the birth of a defective child. *Psychol Stud Child* 16:523, 1961.
17. Johns N: Family reactions to the birth of a child with a congenital abnormality. *Med J Aust* 7:277, 1971.
18. Smithells RW: The thalidomide legacy. *Proc Royal Soc Med* 58:491-492, 1965.
19. Adams SH: The health master, in Strauss M: *Familiar Medical Quotations*. Boston, Little, Brown & Company, 1968, p 458.
20. Chekhov AP: Ivanov, Act I, Scene 2, in *Familiar Medical Quotations*. Boston, Little Brown & Company, 1968, p 458.
21. Hardy HL: Annual discourse—risk and responsibility. *NEJM* 293:801-806, 1975.
22. Rensberger B: Doctor's incompetence. *New York Times* January 29, 1976, pp 1, 24.
23. Robitscher J: The doctor as an occasional witness. *Modern Medicine* 6:78-81, 1969.
24. Rubsamen DS: The evolution of medical malpractice litigation in the United States. *Canad Med Assoc* 113:334-341, 1975.
25. Arthus M: *Philosophy of Scientific Investigation*. Baltimore, The Johns Hopkins Press, 1943.
26. Burke E: The Thirteen Resolutions, in *Bartlett's Familiar Quotations*. Boston, Little, Brown & Company, 1968.
27. Boulding KE: Truth or power? *Science* 190:4213, 1975.
28. Reichman S: Quality assessment and ambulatory care. *Bull NY Acad Med* 52:75-80, 1976.
29. Willig SH: Balance of benefits to risk. *Modern Med* 6:68-69, 1969.
30. Bucy PC: The medical expert witness in malpractice suits. *JAMA* 232:1352-1353, 1975.



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NAMING AND DEVELOPING AN OFFICE MANAGER

Part 1

LEIF C. BECK, LL.B., C.P.B.C.
VASILIOS J. KALOGREDIS, J.D.

As a general personnel management rule, a supervisor is considered necessary if there are at least three employees. Furthermore, it is often said that there should be one supervisor for each seven employees. These ideals apply more or less to small and moderate-sized medical offices, except that applying them woodenly can be as troublesome as not using supervisors at all.

In effect, we consider the designation of an office manager the most critical question facing good medical practice management. With a good office manager intelligently guided by the physician(s), the usual problems of billing systems, collections, third party insurance, scheduling, and so on will probably be well handled. Without the manager, or with the wrong one, there will be enough chaos that the other questions become secondary in importance.

Should One Be Chosen at All?

We make apparently contradictory recommendations as to the office manager question from client to client. In one case we might urge promotion of an excellent employee to full-time manager; in another case we might recommend recruiting a new employee specifically for the role; and in a surprising number of situations we flatly recommend against creating an office manager role at all.

The reasons for our varying recommendations are subjective. In some offices a number of senior assistants might be working well together, perhaps interchanging duties as the needs arise and considering the office their joint responsibility. To name one of them as manager

might destroy the good working environment, and to hire someone from outside the group would probably be destructive.

In other situations the personality and/or attitude of the doctors might make it virtually impossible for any lay individual, no matter how capable and devoted, to function adequately as a manager. We so unfortunately remember some client situations in which small groups of doctors needed good internal management help but caused the selected managers to be inadequate.

Advantages of Having a Manager

While the designation might sometimes be inappropriate, we are convinced that most medical offices will be vastly improved by having an effective office manager. Basically, the intelligent delegation of responsibilities to such a person will relieve the doctors of problems demanding their time and attention. There would be someone within the practice to assure that all systems and employees function well, being directly accountable to the physician(s) for that success.

The commonly recognized office manager responsibility is in personnel management. Doctors typically lack the time or temperament to effectively communicate with their staffs, thus failing to apply the range of sound personnel principles so useful to medical office effectiveness. A manager obviously would have personnel as his or her primary responsibility.

A manager can, however, serve so many additional functions in a busy office. He or she can take responsibility for all the business sys-

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Naming and Developing an Office Manager—Beck

tems, making changes as their need becomes apparent. The manager is far more likely to understand the practice and its intricate workings than is an outside consultant, for example, which is why we usually feel that finding the right person to fill the role will solve many other problems.

He or she can and should also carry out many tasks typically considered doctor-level responsibilities. Contact with the practice's accountant, attorney, and pension investment counsellors, for instance, can better be accomplished by the manager, with the doctors making the decisions based on his or her spade-work. Similarly, details of moving an office or opening a second office, negotiating for equipment or furniture purchases, changing telephone or dictation arrangements, and even helping conduct a doctor's hospital committee responsibilities can in large part be accomplished at the manager level.

Doctors are sometimes skeptical that managing a moderate-sized office is really a busy job. The thought of someone performing no visible office tasks, except to "manage the office," may even tend to annoy the overly busy physician(s) and staff. We subscribe strongly, however, to an old adage which so often proves itself: "The better the office is functioning, the less the manager seems to be doing; and the busier the manager, the less effective is the office."

Perhaps as some indication of what responsibilities an office manager might assume, Table 1 presents a sample job description for the position. Even then, some doctors will protest that it appears insufficient to occupy a person's time. We agree; the position is deceptive. Sometimes we ourselves feel hard put to quantify what will really be done in the job, for the responsibilities are in large part subjective—but nevertheless important.

Categories of Office Manager

We place medical practice managers in three different categories: lay administrators, full-time office managers, and so-called super-aides. Each deserves some description.

A "lay administrator" is a person hired specifically to manage a practice even though he or

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The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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TABLE 1*
POSSIBLE JOB DESCRIPTION FOR OFFICE MANAGER

- | | |
|---|--|
| <p>1. Financial</p> <ul style="list-style-type: none"> a) Preparation of proposed annual budget b) Approval of all expenditures c) Preparation or review, and analysis, of monthly statements d) All special financial studies, reports, etc., requested by doctors or determined necessary by Office Manager e) Liaison with accountants <p>2. Personnel</p> <ul style="list-style-type: none"> a) Recruiting, hiring, and firing b) Supervision, including salary review and proposed adjustments c) Maintain control and records of vacations, sick leave, etc. d) Organize regular office meetings and set agendas e) Determine and change personnel assignments and job descriptions as needed <p>3. Supplies</p> <ul style="list-style-type: none"> a) Order all supplies (medical and clerical) b) Maintain supply records, pricing studies, etc. <p>4. Professional Corporation</p> <ul style="list-style-type: none"> a) Monitoring of fringe benefit programs b) Supervision of pension and profit-sharing funds (as liaison between advisors and doctors) c) Coordination with attorney and accountant on corporate details | <p>5. Collections</p> <ul style="list-style-type: none"> a) Supervise systems for delinquent account follow-up b) Handle difficult collection matters <p>6. Audit Controls</p> <ul style="list-style-type: none"> a) Review and supervise internal systems for handling cash, recording mail receipts, writing checks, etc. b) Follow up audit control systems devised by accountants <p>7. Insurance</p> <ul style="list-style-type: none"> a) Handle and recommend all office and corporate insurance coverages <p>8. Office Facilities</p> <ul style="list-style-type: none"> a) Assure proper maintenance of present office; order new equipment; obtain supplies and services b) Be responsible for all aspects of office maintenance and coordination with landlord c) Investigate and act as agent for doctors in office building ownership, development of plans for office changes, etc. <p>9. Personal for Doctors</p> <ul style="list-style-type: none"> a) Act as business agent for doctors personally in all areas where their time can be saved for medical work b) Carry out assignments for doctors as may be required of their civic, medical, or other committee positions |
|---|--|

*From "The Physician's Office," by Leif C. Beck, *Excerpta Medica* (1977), pp. 46-47.

she has not served in various office roles. The administrator has never been a medical secretary, assisted with patients, sat at the reception desk, or filled out a Blue Shield form. He or she simply has experience as a "manager/supervisor," with a capability of applying those skills and personality traits to a medical office just as to a commercial business.

There is a decided trend in practices of as few as three doctors towards employing a full-time manager from the business field rather than from medical office work. These lay administrators tend usually to be male, a phenomenon of the

job market at the executive level and the biases of many doctors. Whether male or female, we see the trend towards lay administrators as healthy proof of a practice's need for management responsibility.

Our second category of manager is the "full-time office manager." This person, usually female, will have been promoted from one or several regular medical jobs to manager, no longer performing her old jobs. In our own office, for example, our former secretary of long-standing is now our full-time manager—we "took away her typewriter."

Far more practices should follow our approach of converting the highly capable employee into a manager. Selection of the person must obviously consider her intelligence, perceptivity, loyalty, and personality, for one will not be a good manager just because she was a good receptionist, bookkeeper, or whatever. But when an employee has the desired qualities, her pre-existing relationship with both doctors and staff will augment her total acquaintance with the practice to provide an ideal supervisor/executive.

The third category is the all-too-common "super-aide"—the most senior or most conscientious employee who is thus given the additional title of office manager. She is typically given no specific responsibilities except to "coordinate the girls," nor is she relieved of her regular duties enough to have any time for managing.

We consider a practice's naming a "super-aide" as one very small step towards good office management. But so much more can be accomplished if the physician(s) and the selected individual build the role further towards that of a "full-time office manager." If more responsibility is delegated to her and she carries it out well, the expanded role can evolve without being a shock to either side. Some doctors consider the upward trend as a threat, but we see it as their great opportunity.

The Challenge of Developing a Manager

Our emphasis for most (though definitely not all) clients is to move them up the managerial categories. Offices having no coordination will often be well served to designate one assistant as manager—as "super-aide." Many more offices already having such a person should consciously upgrade her role towards that of a truly responsible middle level manager, perhaps all the way to a "full-time office manager." And other offices will have enough challenge and activity to justify recruiting and hiring a person as its executive—its "lay administrator."

In all three cases, there is a real challenge to both the physician(s) and the person so named. The individual will assume new responsibilities which he or she may or may not actually be able to handle. In this respect, we often point out



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that naming an excellent assistant as manager creates a risk—she will likely be lost as an employee if she fails to manage effectively. The "Peter Principle" applies all too well.

There is a greater challenge to the doctors. It is essentially up to them to develop the manager's role and to set the tone for his or her authority with the staff. If a doctor refuses to entrust the manager with higher level concerns, or if he continues to call on her for menial tasks, no real managerial feeling will be created. If the physician undercuts the manager as to personnel matters, the individual will lack the staff's respect for effective supervision.

Therefore a physician must take real pride in developing an employee into the office manager role. A failure to carry out the job effectively is more often the doctor's fault than it is the manager's. Another old adage must be kept firmly in mind: "Someone must manage the manager if he or she will be successful." That someone is, of course, the physician or physicians.

Editorials

INTERPRETATION OF ANTIMICROBIAL SUSCEPTIBILITY TESTS

To be clinically effective, an antimicrobial agent must achieve high enough concentrations at the site of infection to be bactericidal or bacteriostatic. Bacteriostasis is usually adequate in individuals with intact immune mechanisms. The choice of antimicrobial therefore depends upon the minimum concentration required for growth inhibition of the infecting organism and whether this concentration can be achieved at the site of infection without producing toxicity. Other things being equal, cost should also be considered.

In the case of certain species of bacteria and fungi, the minimum inhibitory concentration (MIC) for preferred antimicrobial agents is predictable, eg, group A beta hemolytic streptococci and *Streptococcus pneumoniae* vs penicillin.* For many, however, the lack of predictability requires that each isolate be tested for clinical susceptibility or resistance.

Broth and agar dilution methods directly measure MIC's and act as reference methods; until recently they have been costly and impractical for routine use in the average clinical laboratory.

The Bauer-Kirby (B-K) disc diffusion method was developed in the late 1960's to provide a standardized susceptibility testing method both accurate and economically feasible. Prior to that time, methods used in many clinical laboratories were non-standardized and often grossly inaccurate and misleading. The B-K method is based upon the fact that, using standardized conditions, the zone of inhibition produced by an antimicrobial-containing disc is both reproducible and proportional to the MIC for that agent. Results are reported as susceptible (S) when zone sizes obtained correspond to achievable MIC's, or resistant (R) if they do not. Measurements falling into a buffer zone between S and R usually cannot be interpreted and are reported as intermediate (I).

The adoption of the B-K procedure nationwide

*The recent recognition of 3 lactamase producing strains of *S. pneumoniae* and *N. gonorrhoeae* emphasizes the importance of periodic re-examination of "predictable" strains.

has greatly improved the accuracy of susceptibility testing. There are limitations of the method, however, with which one should be familiar. The division between susceptible and resistant is based upon serum levels achieved following a recommended dosage and route of therapy. If the concentration of antimicrobial agent at the infection site differs significantly from that achieved in blood, a false determination of resistance or susceptibility may result. With few exceptions, peak urinary levels 5 to 100 times respective serum levels are achieved with commonly used antimicrobials. In urinary tract infections, excellent clinical response may occur even though infection agents are reported resistant by the B-K technique.** This accounts for the observation that many urinary tract infections with *E. coli* or other "resistant" gram-negative rods respond clinically to penicillin G.

In contrast, bile levels of gentamicin are significantly lower than serum levels. A biliary tract infection with a strain of *E. coli* susceptible to gentamicin in the B-K test may not respond to treatment with this agent.

The fact that S or R is based upon a recommended dosage and route of administration may also be misleading. Moreover, included under S or R are organisms whose MIC's vary from very low to very high. A susceptible organism may have an MIC well below achievable levels or only slightly below, and resistant strains may have MIC's slightly above achievable levels or be well out of reach. For these reasons, lower doses may be used for highly susceptible strains and when toxic:therapeutic ratios are favorable, a B-K resistant strain may be effectively treated by increasing the dose or changing the route of administration.

Because of technological advances, MIC determinations by micro-titer methods are now economically feasible. Because of this and the limitations listed above, many laboratories are converting from the B-K method to the MIC procedure. Susceptibilities will ultimately be reported as the concentration required (μ /ml) to inhibit the organism. Also provided will be the necessary pharmacologic data for their interpretation; thus based upon this information,

**Sulfonamides, nitrofurantoin and nalidixic acid are exceptions since S and R determinations are based on levels achieved in urine.

a more scientific selection of antimicrobial agents can be made.

R.C.K.

✻ ✻ ✻

BRAVO!

What brings out the worst in people? Gastroenteritis? No, malpractice actions! You probably have considered malpractice suits a plague, figuratively. Doctor Brent considers them as a disease, and studies them the way we study diseases — their etiologies, epidemiologies, and complications, and tells us how those afflicted, plaintiff as well as defendant, are made sick. Are you tired of the idea that medicine and law have different notions of "truth"? Read this and see how scientific medical inquiry reveals truths that doctors can understand and that lawyers will have to deal with. Bravo for Doctor Brent!

MARTIN GIBBS, M.D.

✻ ✻ ✻

MORE, NOT LESS

In the article by Duncan on "Genetics in Clinical Medicine" several examples of genetic disorders are given along with genetic counselling by his clinic. The problems presented are excellent examples of genetic disorders that one might encounter in any clinical center dealing with malformations. Our experience at the Wilmington Medical Center has demonstrated that this is a basic need of any clinical department although the question will probably arise more often on a pediatric and obstetrical service.

In view of the need for more, not less, genetic counselling, it is quite distressing that The National Foundation March of Dimes has indicated, at least by press release, that they are cutting back in funds available to support genetic counselling centers. This is quite disturbing in view of the need of families to have an authoritative source from whom to obtain appropriate information on risks of future pregnancies. The number of disabilities and malformations that have a hereditary basis is large. The perpetua-

tion of birth defect centers and genetics clinics is necessary to make it possible for the physician involved in these clinics to become fully acquainted and develop an in-depth knowledge of congenital malformations, genetic disorders, and other related birth defects.

H.R.

✻ ✻ ✻

JUST AS GOOD AND 23% CHEAPER?

In the February, 1978 *Bulletin* of the American College of Physicians, Dr. James Clifton, President of the ACP, reported that 40% of the medical students who were graduated in 1976 headed for residencies in internal medicine, 13.3% were family practice bound, and 10% were going into pediatrics.

The same issue summarized a *JAMA* report (December 26, 1977) on current and projected numbers of American medical students. Last year there were more than 58,000 medical students enrolled in American schools, an increase of 2,000 from the preceding year. About 13,600 students were graduated last year, and the schools project that the number graduating will increase to 16,000 annually in the next three or four years. Family medicine is now included in the curriculum of 102 of the 116 US medical schools.

The same ACP *Bulletin* included a resume of new legislation relevant to medical affairs which has been approved by the California Medical Association and was due to have been signed by Governor Brown on January 1, 1978. One of these new laws authorizes ten five-year pilot projects in which physician's assistants, registered nurses, and pharmacists will be permitted to prescribe, dispense, or authorize certain drugs. No mention of the enthusiasm or lack thereof by the California Medical Association was included in the resume.

The same evening that I read the information in the above paragraphs, I also read an article in the February 9th *New England Journal of Medicine* entitled, "Efficiency and Cost of Primary Care by Nurses and Physicians's Assistants." The gist of this most important article

Editorials

is this: In a randomly assigned patient trial, new health practitioners (NHP), including registered nurses trained on the job by the Southern California Kaiser Permanente Health Facility and physician's assistants, were found to be just as able as physicians to care for patients with four common acute complaints: symptoms of urinary tract infection, upper respiratory infection, headache, or abdominal pain. The NHP followed protocols for evaluation and management of these four problems, conferring with physicians *only when they (the NHP) felt it indicated*. The overall clinical results were judged about the same with respect to all the parameters evaluated, including quality of care but excluding cost. The cost of the NHP-delivered care was less because the NHP average annual salary with fringes, was \$14,494 vs \$43,680 for the physicians, so the NHP care cost less even if it took a little longer—which it did, but just barely. In a nutshell, the care by NHP's, whether they were on-the-job trained nurse practitioners or formally trained physician's assistants, was judged as good as and cheaper than care by doctors.

What is most important is that the staffing patterns of the clinic which did this study have been changed as a result of their findings. Before this study, ten physicians and three NHP's saw approximately 2,700 patients monthly. Now six and a half physicians and six NHP's see 2,900 patients per month. That's \$480,282 in salaries before vs \$370,884 in salary after, a 23% decrease in salary budget.

As a basis of my evening's reading, I am forced to wonder where and how will last year's 60 plus percent of students who chose medicine, family practice, or pediatrics be practicing when they finish their residencies? What is going to be the eventual medical career of the class of 1981? Will there be places for them in the United States Health Care System when they finish?

On a personal note, my oldest child is now in medical school, with my blessing and at my expense. Was it prudent of me to have encouraged medicine as a career?

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FAMILY THERAPY, THEORY AND PRACTICE edited by Philip J. Guerin, Jr., M.D., Gardner Press, Inc., New York, 1976. 553 pp. Price \$24.50.

This book, sponsored by the American Orthopsychiatric Association, an organization with a psycho-social orientation, commemorates a quarter century of family therapy. Although the title implies that this is a specific treatment modality, it gradually becomes evident that the term covers many treatments, with or without a rationale, varying in method and in goals. What these treatments have in common is that they work with the family. Who constitutes the family will be different from one treatment center to another or will vary according to the core of disorder under consideration. But as one contributor states it, "We are essentially trying to change ways in which family members deal with one another . . ."

The first section, including the editor's leading chapter, is a history of the field in a chatty, anecdotal fashion relating the trials and tribulations of some of the early leaders and followers. There is some excellent discussion of the theoretical bases of family therapy by various contributors, notably Murray Bowen. But some authors tend to disparage the need for, and side step, the matter of conceptual formulations. The third and fourth parts focus on practical considerations of what happens in family therapy, who is involved, and clinical problems treated as a family matter. For example, there are chapters on children, schizophrenia, alcoholism, sexual dysfunction, and chronic asthma. A few chapters deal more specifically with techniques and procedural methods.

Perhaps there are some advantages in having a book written by many contributors, but I see no benefits from the diversity presented in this collation of articles of uneven quality.

Some outstanding names are missing from the list of contributors. But the main problem here, as in many symposium-type books, is that it lacks a cohesiveness and systematic development of a

theme. The book is interesting for those in the field of family therapy, but there is little new. And students will get more out of periodical literature.

NORMAN TAUB, M.D.



FIRST, YOU CRY by Betty Rollin, J. B. Lippincott Company, Philadelphia, 1976. 206 pp. Price \$7.95.

Betty Rollin has a gift for writing that makes for very easy reading. Her account of her experiences preceding, during, and immediately following her radical mastectomy for breast cancer is entitled *First, You Cry*. Be it first or last, crying is part of her tale. However, I'm not sure that Ms. Rollin's easy-going style convinced me that all her crying was provoked by her breast cancer and its attendant experiences.

Ms. Rollin starts the tale by portraying herself as a classic "Jewish-American princess." Immediately my nape bristles with stiff little hairs! Her repetitive assertions of her ethnic handicaps and gifts lay just a little heavy on my sensibilities. Add to this indiscretion the frequent punctuation of her writing by four letter words and frank descriptions of her sexual successes and failures, and I find myself uncomfortable in my victorian integument. My women, think I, are not so crass or brazen as to advertise their privacies so patently. Why Ms. Rollin?

We find, on further reading, the oft-repeated saga of terror at the thought of mutilation, horror at the prospect of lessened sexual allure, and abject fear of death—all frequently camouflaged by cavalier and hale-fellow, well-met, stiff-upper-lip behavior. Those involved with breast surgery patients are familiar with the emotional caricature that Ms. Rollin so well portrays.

I think, however, that Ms. Rollin was more revealing than she had intended. When done, the battle scene was divided into two grounds—one, the campaign against the cancer, and the

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other, the foray against the author's failure of interpersonal relationships. She had an unsatisfactory relationship prior to her cancer, found a ready excuse in the cancer for its termination, and ran to an even more unsatisfactory experience in the aftermath. And where do you think she wound up at the end of the book—nine months after the surgery? You're right! Back with the first unsatisfactory relationship. For a woman with such lucid descriptions of emotions, the author has painfully meager insight into her own.

I had the feeling that Betty Rollin could have written much of the biography even had she not had a cancer happening, since much of the book is unrelated to the cancer thing itself. One must not confuse independent, unstable love relationships with the emotional derangements that might surely follow in the wake of a mastectomy, especially in a young woman. The author dips deeply into this post-hoc reasoning to justify much of the book.

For those who wish light reading and earthy words, I commend *First, You Cry*, but if you have anything better to do with your time—do it.

CARL I. GLASSMAN, M.D.

THE TROUBLED ADOLESCENT by Ernest A. Hirsch, Ph.D., International Universities Press, Inc., New York, 645 pp. Price \$22.50.

The title of this book is highly provocative, until one reads the subtitle: "As He Emerges on Psychological Tests." What the book is, really, is an engagingly informal account of psychological tests given to a number of representative youngsters at the Menninger Foundation while the author was evidently a junior staff member. No generally applicable formulations or diagnostic guidelines are given in the fifteen-page "Introduction" or the five-page "Final Thoughts," but some interesting and wholesome attitudes toward the usefulness of psychological testing in diagnosis and treatment are reflected.

This is a modest volume, to be enjoyed by students and journeymen of clinical psychology, and by any psychiatrist or other physician who appreciates the surveillance of clinical material from someone else's cases, which might spark some recollection or insight from his own experience.

ROBERT W. BUCKLEY, M.D.

❖ ❖ ❖

ANNUAL REVIEW OF MEDICINE — SELECTED TOPICS IN THE CLINICAL SCIENCES edited by William P. Creger Vol. 27, Annual Reviews, Inc., Palo Alto, California, 1975. 530 pp. Price \$17.00 Paperback.

A text encompassing a subject or subjects in sufficient degree and employing the word "review" in its title, should have, at least according to this reviewer's opinion, a set of guidelines: simplicity, clarity, current knowledge, and an interesting topic (topics). In this particular edition, these features are all present, some to a greater degree than others, depending on the author and topic under discussion.

Admittedly, one's personal prejudices influence the way one goes about reading such a text. It should be apparent that the areas discussed in the reviewer's area of interest are more likely to be read and pondered over than those which have little interest to the personages reading the text. The final result may tend to be somewhat

skewed in favor of, or against, certain topics covered.

The broad range offered in this particular review offers a wide enough variety so that it will be with an extremely jaundiced eye that this reviewer will peer at someone unable to find several worthwhile and interesting sections.

The major specialty fields are all represented: cardiology, dermatology, endocrinology, gastrointestinal, hematology, infection, kidney, neurology, respiratory, and psychiatry. There is even a "miscellaneous" for those among us who can't make up their minds.

The contents offer, in the majority of topics, small presentations of a particular area. They are certainly not as extensive as they might have been. Further references are presented for those feeling inquisitive and restless upon finishing the presentations.

All in all, this review is an interesting way to touch all bases broadly, albeit lightly.

ETHAN FLAKS, M.D.

✱ ✱ ✱

CLINICAL VECTORCARDIOGRAPHY AND ELECTROCARDIOGRAPHY by Jan D. Cooksey, M.D., Marvin Dunn, M.D., and Edward Massie, M.D., Year Book Medical Publishers, Inc., 1977. 759 pp. Illus. Price \$39.95.

The authors have set out to prepare a text which reflects the latest information on the electrovectorcardiology of arteriosclerotic, rheumatic, congenital, and pulmonary heart disease.

Their basic framework involves four sections—normal ECG/VCG with basic theory, abnormal ECG/VCG, cardiac arrhythmias, and other conditions—not a striking departure from current reference works in the field.

This text does, however, provide several refreshing, if not strictly innovative, approaches to its subjects.

First of all, the basic theory sections for both ECG and VCG provide scientifically rigorous treatments of the fundamentals underlying these

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disciplines. The description of the strengths and weaknesses of the dipole concept of cellular electrical activity is worthy of a good basic physics text, and the sections on instrumentation and lead systems are equally thorough and detailed.

Secondly, although the factual content of the sections on clinical application is rather standard, the presentations are studded with descriptions of the studies from which the clinical ECG/VCG criteria are derived—ie, this is not simply a catalogue of standards, to be applied blindly, but an orderly, logical synthesis of conclusions based on theoretical and experimental grounds.

Finally, the text is profusely illustrated with ECG's, VCG's, and cardiac schematics, all of which add to this book's ability to provide understanding as well as knowledge.

In summary this text provides an in-depth analysis of electrovectorcardiography.

It would be a justifiable addition to the library of any cardiologist or internist and a must for a

Book Reviews

medical library. The basic sections would be excellent introductions for medical students.

MICHAEL STILLABOWER, M.D.



SEXUAL OPTIONS FOR PARAPLEGICS AND QUAD-RIPLEGICS by Thomas O. Mooney, Theodore M. Cole, M.D., and Richard A. Chilgren, M.D., Little, Brown and Company, Boston, 1975. 111pp. Illus. Price \$8.95 Paperback.

There are 120,000 or more paraplegics and quadriplegics who live in the United States today. This book is a graphic guide to the technicalities of sexual intercourse for them; it is dedicated "to the illumination of dark corners."

"Virtually nobody is too disabled to derive some satisfaction and personal reinforcement from sex—with a partner if possible, alone if necessary," says Alex Comfort in his foreword which begins with a quote from Sartre ("Hell is other people") and continues by saying that nobody knows this better than the disabled.

Though this book is designed specifically for a particular audience—paraplegics and quadriplegics—it can probably be read with profit by all physicians. "... these illustrated pages have the greatest importance for the able-bodied majority in our culture. It is they who cast the burden of societal guilt for their physically disabled brethren. They feel the uneasiness and distaste that feed on misinformation and inadequate exposure. They react in a manner that ostracizes the physically disabled from the everyday world created by and for the able-bodied."

I cannot see how anyone can read the brief text or look at these explicit pictures of love-making couples burdened with fecal and urinary collection apparatus without counting anew his blessings.

CLINICAL ENDOCRINOLOGY A SURVEY OF CURRENT PRACTICE edited by Calvin Ezrin, John O. Godden, and Paul G. Walfish, Appleton-Century-Crofts, New York, 1977. 334 pp. Illus. Price \$18.50.

I do not see much to recommend this book over longer and more comprehensive treatments of the same subject. Dr. Nicholas Forbath's chapter, "Hypoglycemia; Hazard to Neurons, Haven for Neurotics," is admirably named, and a good review.

DIABETES EXPLAINED: A LAYMAN'S GUIDE by Ira J. Laufer, M.D. and Herbert Kadison, Saturday Review Press, New York, 1976. 179 pp. Price \$7.95.

Why are books for laymen so much less expensive than books for doctors? Dr. Laufer's patient, Mr. Kadison, Director of Public Relations for NYU Medical Center, has been a diabetic for a number of years. This book, an outcome of their relationship, may be recommended to any of your patients who are diabetic. I think most doctors would also profit by reading it since so much of the diabetic literature for physicians is research oriented rather than a review of basic clinical problems.

The six criteria for good diabetic control, the best I have seen, are reproduced here in a slightly abbreviated fashion: 1. Patient feels well; no symptoms hypo- or hyperglycemia. 2.

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Amen, particularly to the last precept.

CLINICAL MANAGEMENT OF THE OSTEOPOROSSES by **Gilbert Gordan, M.D.**, and **R. N. Vaughan**, Publishing Sciences Group, Inc., Littleton, Massachusetts, 1976. 207 pp. Illus. Price \$18.00.

The authors of this well-written book neatly distinguish osteoporosis (normal mineralization) from osteomalacia (abundant but uncalcified osteoid). Although written before the brouhaha about estrogen, this book is still worth reading by those who have the responsibility of helping menopausal women evaluate the risk/benefit of estrogen therapy, especially if symptoms or signs of osteoporosis develop. A simply written book, easy to read, it includes 47 pages of references, literally from A (J. E. Aaron) to Z (J. T. Zajtchuk).

JOURNAL OF MEDICAL SYSTEMS by **Ralph R. Grams, M.D.**, Plenum Press, New York, 1977. Price \$22.50 for personal use, \$45.00 non-personal use (4 issues).

The first volume of this new journal, inaugurated in response to "a pressing need for a periodical that will collect, evaluate and communicate our expanding knowledge and capabilities in the field of health care delivery technology," includes articles on hospital information systems in California, laboratory computer use to identify enterobacteriaceae, discussion of noise specifications for hospital communication systems, and a confirmation of the rumor that "the technological influence of computers has caused more problems (or phrased more appropriately, has caused more issues) to surface than it has resolved, and there is no doubt that it will continue to do so."

The great span of topics indicates the great range of applications of medical computing. \$45 a year (4 issues) unless you certify the journal is for your personal use, in which case the price drops to \$22.50.

BERNADINE Z. PAULSHOCK, M.D.

FIGHTING INFECTION — CONQUESTS OF THE TWENTIETH CENTURY by **Harry F. Dowling, M.D.**, Harvard University Press, Cambridge, Massachusetts, 1977. 339 pp. Price \$15.00.

Harry Dowling, an outstanding infectious disease researcher and clinician, has written an exciting history of the conquest of infectious disease during the past three-quarters of a century.

Dr. Dowling made significant contributions to this effort, but he is particularly well-known in Delaware because, following his retirement from the University of Illinois, he served as advisor to the President of the University of Delaware on medical affairs. Some of us who had known Dr. Dowling only casually before had the opportunity to appreciate his vast medical knowledge, dry wit, and ability for organization. All of these attributes are evidenced in his latest book published this past October.

In this volume, he describes the status of the science of infectious disease at the beginning of the twentieth century and then details the con-

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quest of these diseases by public health measures, immunizations, and antibacterial agents. Appropriately, he provides considerable detail on streptococcal infections, tuberculosis, the venereal diseases, and poliomyelitis, since these maladies were of such paramount importance.

Dr. Dowling's style is easy to read, and he has accomplished the difficult task of writing for the layman without "talking down" to the physician. The occasional explanation of a medical term for the lay reader is handled unobtrusively and was not annoying to this reviewer.

Dr. Dowling has placed considerable emphasis on the tremendous team effort that resulted in the marked advances in the control of infectious disease since 1900. I am impressed with the heterogeneous group of individuals who participated in the development of vaccines and antibiotics. Perhaps even more important are the details concerning the cost of the development of vaccines and antibiotics. At a time when the pharmaceutical companies are under considerable fire from the American public and the federal government, we should be reminded that Lederle Laboratories lost 10 million dollars in the development of a polio vaccine alone. This fact should underline the point that these companies need to recoup a profit to cover their tremendous expenditures. Since we are threatened by increasing federal bureaucracy, we realize that our federal government could not have duplicated the accomplishments of private industry in providing antibiotics and vaccines for the entire world.

This book is highly recommended for those interested in medical history and should be read by clinicians who are prescribing the many antibiotics and vaccines discussed by Dr. Dowling.

WILLIAM J. HOLLOWAY, M.D.

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FIGHTING INFECTION — CONQUESTS OF THE TWENTIETH CENTURY by Harry F. Dowling, M.D., Harvard University Press, Cambridge, Massachusetts, 1977. 339 pp. Price \$15.00.

"The abundance of effective measures now available for the cure and prevention of infec-

tions would have been impossible without the improvements in education, the advances in industrial technology and the increasing concern for human welfare developed in the United States and elsewhere."

The preceding sentence, taken from the preface of Dr. Harry Dowling's book entitled *Fighting Infection—Conquests of the Twentieth Century*, illustrates the main theme of his effort, which is that the development of drugs and effective medical procedures to combat infectious diseases has been a painstaking additive process.

Dr. Dowling emphasizes that, while a few names have received much publicity, eg, Alexander Fleming for penicillin and Jonas Salk for the polio vaccine, in actuality, virtually all advances in development of new drugs to treat infection have come through methodical trial and error research conducted by scores of scientists.

Shortcomings of the medical society, both past and present, are discussed in this book. Specifics include the chaotic state of medical practices that existed in this country at the turn of the century and beyond, sometimes incorrect or over-prescription of antibiotics by some doctors, and occasional haste by the pharmaceutical companies in developing new drugs.

The tightening of the requirements for medical education and the reduction of quackery did much to aid the development of a higher level of respect for doctors in this country and, therefore, increased public acceptance and financing of the fight against infection. Perhaps Dr. Dowling could have spent more time discussing improvements in the medical profession as a whole as this seems to have been an important factor in victories over infectious diseases.

One service Dr. Dowling provides in his book is to make clear to the general public why the decision to proceed with the swine flu vaccination program was made in 1976. His discussion of past influenza pandemics and the effectiveness of vaccines indicate that US health officials felt they had little choice but to inoculate the entire population.

While the lay reader might feel bogged down

by medical terminology and detail, trying to keep straight the differences among antitoxins, serums, and vaccines, this is still a readable book, especially when it deals with the human side of the struggle against infectious disease.

WILLIAM J. HOLLOWAY, JR.

1977 YEAR BOOK OF DERMATOLOGY edited by Frederick D. Malkinson, M.D. and Roger W. Pearson, M.D., Year Book Medical Publishers, Chicago, 1977. 412 pp. Price \$23.50.

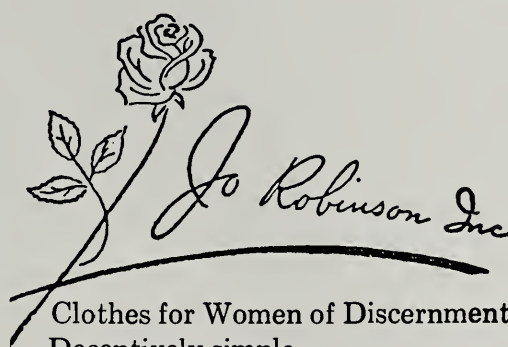
This book is largely based on summaries of the most important articles published in the field of dermatology during the last year with comments by the editors stressing the importance and/or significance of each article. Included are excellent reviews of several disease entities, especially the one on pemphigus. Also included is an up-to-date review of many of the drugs that have caused drug reactions, their treatment, and the relation of pemphigus to many systemic diseases. There are several good summary articles on the current recommended treatment of syphilis and some new data which question the adequacy of benzathine penicillin in the treatment of tertiary syphilis (neurosyphilis).

This book is probably a necessity for any dermatologist who doesn't have the time to consistently keep up with the literature. Much of the information, especially the chapters entitled "Advances in the Diagnosis and Treatment of Blistering Diseases, A Selective Review" and "Treatment and Treatment Reactions" are of significant importance to any internist.

HOWARD LEIBOWITZ, M.D.

BLOOD POLICY: ISSUES AND ALTERNATIVES edited by David B. Johnson, American Enterprise Institute for Public Policy Research, Washington, D.C., 1977. 212 pp. Price \$4.75. Paperback.

This publication contains the edited proceedings of the June, 1976 conference sponsored by the Center for Health Policy Research of the American Enterprise Institute. The purpose of the conference was to bring together blood bankers, doctors, government regulators, and



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scholars of divergent viewpoints to discuss recent and proposed policies relating to the procurement and distribution of blood. In the introduction the editor sets the stage by describing "the blood market." The volume is then divided into three parts. Part one deals with medical, legal, and economic aspects of blood. Part two offers the answer of Harry M. Meyer, Jr., M.D. to the question, "Does government regulation work?". Part three offers descriptions of certain current practices and suggested reforms. All together there are nineteen major contributors to this conference with only a few pages devoted to comments from the audience.

This paperback volume of 212 pages does not succeed in airing all of the viewpoints held by the many professionals involved in blood-banking. Nor does it fully expose the political dimensions of the several conflicts involved in discussion and implementation of the National Blood Policy. It is of limited value to those who are active participants in the debate concerning the collection and distribution of our national blood resource.

JOHN J. EGAN, M.D.

❖ ❖ ❖

PSYCHIATRIC SLAVERY by Thomas Szasz, The Free Press, New York, 1977. 159 pp. Price \$8.95. Paperback.

This is a very readable book, primarily because Dr. Szasz writes well. He has had a good bit of experience at it, as this is approximately his tenth full-length book on essentially the same theme: that much of the ceremony and mystery of psychiatry is used in support of an impatient society and buck-passing Courts of Law, to characterize as "insane," "crazy," or "psychotic," persons who are inconveniently deviant. This is a worthwhile theme, and responsible psychiatrists, lawyers, and other professionals have risen to the challenge in numerous ways, to modify psychiatric practice and legislative enactments so that deviant members of the society will be less likely to be rejected out of hand and confined in "mental institutions," just for being different. Dr. Szasz, though, finds it more expedient to place himself as a sort of nihilistic Messiah, and to decry all that is going on as in-

consistent with his principles of freedom to be crazy.

In this book, he atomizes the long and tortuous Court battles of Mr. Donaldson and Dr. O'Connor, which began in the Florida courts and wound up in the United States Supreme Court, weaving its way through a maze of issues about involuntary confinement, dangerousness, and right to treatment. Dr. Szasz finds fault with the performances of Mr. Donaldson, Dr. O'Connor, counsel for both sides, the various interested groups which volunteered as friends of the Court, and, just for good measure, the United States Supreme Court itself. He is probably quite right that almost everybody in the entire predicament was in the wrong place at the wrong time, but he would be better advised, in the opinion of this reviewer, to sympathize with the search of numbers of honest men for solutions to a dilemma that is as old as society: what do we do with persons who cannot live up to the unbearably complicated rules and regulations our ancestors have set up for us?

ROBERT W. BUCKLEY, M.D.

❖ ❖ ❖

CURRENT PEDIATRIC THERAPY 7 edited by Sydney S. Gellis, M.D. and Benjamin M. Kagan, M.D., W. B. Saunders Company, Philadelphia, 1976. 781 pp. Price \$28.50.

The editors are professors of pediatrics at Tufts University in Boston and at University of California at Los Angeles. This is the seventh edition of their text. The majority of the articles are newly written, and 121 of the 263 contributors are new to this edition. Each article is concise and targets the practical therapeutics of a specific clinical problem. For the first time there is a separate section on adolescent medicine. Topics not previously discussed include premarital counselling, office gynecology, battered child syndrome, hemodialysis, intra-uterine growth retardation, and drug therapy for sleep disturbances.

Drs. Gellis and Kagan have aimed at a collection of articles to serve as a ready desk reference for busy physicians to help in the daily task of caring for sick children; they have succeeded.

DAVID PLATT, M.D.

In Brief

Speakers on "Ask the Doctor"

Speakers for May 1978 on the Tuesday radio program (11:05 a.m., WDEL) produced by the Medical Society of Delaware are: May 2, *Gordon A. Bussard, M.D.*, Intraocular Lens; May 9, *Alan J. Fink, M.D.*, Sleep Disorders; May 16, *Moses Hochman, M.D.*, Smoking during Pregnancy and Smoking and Oral Contraceptive Use; May 23, *Robert B. Brereton, M.D.*, Risk Factors in Medicine; May 30, *Dene T. Walters, M.D.*, House Call.

In the News

Henry R. Cowell, M.D., Wilmington, has been elected President of the American Orthopaedic Foot Society. The Society is comprised of orthopaedic surgeons interested in improved foot care through research and education.

Recent gubernatorial appointments are: *Frank T. O'Brien, M.D.*, Wilmington, reappointed to the Council on Environmental Control; and *John E. Benzel, M.D.*, and *Marvin V. Andersen, Jr., M.D.*, both of Wilmington, appointed to the Board of Medical Practice.

Floyd S. Cornelison, Jr., M.D., Wilmington, won first prize in the adult category for beauty, craftsmanship, and design at the Annual Kite-Flying Contest at Henlopen State Park on March 24. Earlier Dr. Cornelison had won the Bahadur Trophy at the Annual Kite Fly at the Smithsonian Institute.

New officers for the Delaware Academy of Medicine are: *Robert B. Flinn, M.D.*, President; *William D. Wendle, D.D.S.*, First Vice-President; *Robert L. Meckelnburg, M.D.*, Second Vice-President; *Charles S. Riegel, M.D.*, Secretary; and *Edwin L. Granite, D.D.S.*, Treasurer.

New Delaware Society of Internal Medicine officers are: *Gustave Berger, M.D.*, President; *R. Walter Powell, M.D.*, President-Elect; *Richard H. Morgan, M.D.*, Secretary-Treasurer; *Roger B. Thomas, Jr., M.D.*, Senior Councilor; and *Roger Stevenson, M.D.*, Junior Councilor.

Asbestos and Cancer

Attention is called to a current article in the March-April 1978 issue of *Ca Journal for Clinicians*: "Asbestos-Associated Diseases in United States Shipyards" by Irving Selikoff, M.D., and E. C. Hammond, Sc.D. The US Navy and DHEW have just released information on the subject. Some Delaware physicians are certain to have patients who worked in US shipyards during World War II.

Infectious Disease

The Delaware Lung Association, the Delaware Academy of Medicine, and the Wilmington Medical Center will sponsor the 15th ANNUAL INFECTIOUS DISEASE SYMPOSIUM, May 1 and May 3-5. The opening session on May 1 will be held at the Henlopen Hotel, Rehoboth Beach. Subsequent sessions will be held at the Delaware Academy of Medicine, Wilmington. The program is acceptable for 20 prescribed hours by the American Academy of Family Physicians and 20 hours credit for AMA Physician's Recognition Award, Category I. For information contact: Mrs. Mary C. Humpton, Infectious Disease Research Laboratory, Wilmington Medical Center, P.O. Box 1668, Wilmington, Delaware 19899. Telephone: (302) 428-2744.

David Flett duPont Lecture

The Delaware Heart Association, Inc. and Heart Fund will sponsor the 1978 DAVID FLETT duPONT MEMORIAL LECTURE, to be held at the Quarterly

In Brief

Meeting of the New Castle County Medical Society, May 16, 8:00 p.m., Delaware Academy of Medicine, Wilmington. William P. Castelli, M.D., Director of Laboratories, Heart Disease Epidemiology Study Center, Framingham, Massachusetts, will speak on "HDL, Cholesterol, and other Lipids in the Risk of Heart Disease." For information contact: Mr. Richard W. Jorgensen, Executive Director, Delaware Heart Association, Inc. and Heart Fund, 654-5269 (Wilmington), 856-7386 (Georgetown), 734-9321 (Dover).

Laetrile Research The National Cancer Institute requests the cooperation of physicians in the referral of cancer patients who appear to have benefited from the use of Laetrile therapy. Cancer patients are eligible for evaluation if they have biopsy-proven cancer with objective evidence of anticancer response as documented by scans, x-rays, physical exams, or other means, during a period when the patient was treated only with Laetrile therapy. Conventional therapy at some time during the patient's treatment is acceptable, as long as there was at least a one-month period when Laetrile therapy alone was used. Interested physicians should contact: Neil Ellison, M.D., Laetrile Review Office, Landow Building, Room C808, 7910 Woodmont Avenue, Bethesda, MD 20014. Telephone: (301) 496-9326.

Funds for Leukemia Research

Applications are now being accepted by the Leukemia Society of America, Inc. for grants to clinicians and basic researchers whose work is aimed at finding a cure or control of leukemia and allied diseases of the blood-forming organs. All grantees must hold doctoral degrees and are required to concentrate on

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research relevant to leukemia or lymphoma. Application forms may be obtained from Dr. Rose Ellison, Leukemia Society of America, Inc., 211 East 43 Street, New York, New York 10017. Deadline for completed applications is October 1, 1978 with grants effective in July 1979.

CLINICAL NOTICES AND MEETINGS

ACP Courses

The American College of Physicians will sponsor the following courses which may be used to fulfill Category I requirements for the AMA Physician's Recognition Award. For information contact: Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, PA 19104.

INTERNAL MEDICINE: RECENT ADVANCES IN DIAGNOSIS AND TREATMENT, Cincinnati, Ohio, June 5-9.

CRITICAL CARE MEDICINE 1978, Banff, Alberta, Canada, June 14-17.

INFECTIOUS DISEASES, Winnipeg, Manitoba, June 23-26.

ASIM Annual Meeting

The American Society of Internal Medicine will hold its **ANNUAL MEETING**, May 4-7, Hyatt Regency Hotel, San Francisco, California. The meeting will feature programs on government health programs, proposed drug legislation, rationing medical care, physician's health problems, stress as a health factor, and holistic medicine. The meeting is open to the public, and there is no registration fee. For further information write ASIM, 535 Central Tower Building, 703 Market Street, San Francisco, California 94103. Telephone: (415) 777-1000.

Office Dermatology

The American Academy of Dermatology will hold a postgraduate course for physicians, **OFFICE DERMATOLOGY**, May 4-6, Atlanta, Georgia. The program has been approved for 12 credit hours in Category I. For information contact: American Academy of Dermatology, 820 Davis Street, Evanston, Illinois 60201.

Lung Cancer Conference

The International Association for the Study of Lung Cancer will host a conference on **LUNG CANCER**, May 10-13, Hilton Head Island, South Carolina. The conference is open to physicians, other health professionals, and research scientists engaged in clinical and research aspects of lung cancer. For information contact: IASLC Medical Arts Foundation Building, 1603 Oakdale Street, Houston, Texas 77004.

ACS Courses

The Chicago Committee on Trauma of the American College of Surgeons will hold the **22nd ANNUAL POSTGRADUATE COURSE ON FRACTURES AND OTHER TRAUMA**, May 10-13, Chicago, Illinois. For information contact: John M. Beal, M.D., Department of Surgery, Northwestern University Medical School, 303 East Chicago Avenue, Illinois 60611.

Study of Headaches

The American Association for the Study of Headache will present the **20th ANNUAL MEETING OF THE AMERICAN ASSOCIATION FOR THE STUDY OF HEADACHES**, June 17-18, St. Louis, Missouri. The Annual Harold G. Wolff, M.D. Lecture Award will be presented for the best research paper done on headache, head pain, or the nature of pain itself, during the past year. For information contact: Seymour Diamond, M.D., Executive Secretary, American Association for the Study of Headache, 5252 N. Western Avenue, Chicago, Illinois 60625. Telephone: (312) 878-5558.

Medical Symposium

The University of Delaware and Jefferson Medical College will hold the **EASTERN SHORE MEDICAL SYMPOSIUM**, June 18-24, Rehoboth Beach, Delaware. The program is accredited for 30 Category I hours by the AMA and AAFP, and credit in Category 2-D, A.O.A. Telephone: (302) 738-8155.

Care of Children with Cancer

The American Cancer Society will hold the **NATIONAL CONFERENCE ON THE CARE OF THE CHILD WITH CANCER**, September 11-13, Boston, Massachusetts. The program is accredited for continuing education. For information write: Sidney L. Arje, M.D., American Cancer Society, National Conference on the Care of the Child with Cancer, 777 Third Avenue, New York, New York 10017.

In Brief

Colo-Rectal Cancer Conference

The Second Annual Regional Nurses' Conference, MANAGEMENT OF COLO-RECTAL CANCER, sponsored by the Delaware Cancer Network, with the cooperation of the University of Delaware Continuing Education Division of the Division of Nursing and the American Cancer Society, Delaware Division, will be held on June 15-16 at the Hotel duPont. The conference is open to all nurses and supportive health care professionals. Preregistration is required. Contact Joanne P. Tully, R.N., Senior Nurse Coordinator, Delaware Cancer Network, 1202 Jefferson Street, Wilmington, Delaware 19801. Telephone: 428-2112.

CLASSIFIED AD SECTION

Advertisements under the Classified Ad Section are charged at the rate of 30 words or less, set solid. One insertion \$4.00. Call the Journal office, 658-7596 for further information or placement. All advertisements are payable in advance. The Editorial Board reserves the right to edit copy. Closing date for new copy is the first of the month for inclusion in the current issue.

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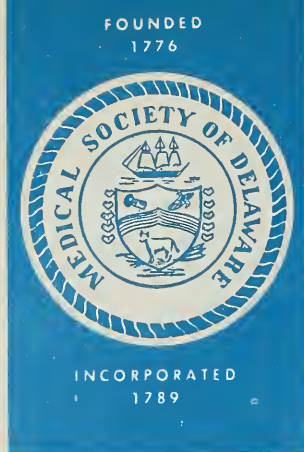
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cancer communiqué

FROM THE DELAWARE CANCER NETWORK*

MAKE TODAY COUNT — KENT AND SUSSEX COUNTY CHAPTER

CAROLE GIBSON, R.M., B.S.
DORIS HATFIELD, R.N.

The Kent and Sussex County Chapter of Make Today Count was formed as a result of the expressed concerns of cancer patients encountered in the Tumor Control Clinics, and their contact with the Wilmington Chapter of Make Today Count. A support group provides a sense of sharing and caring for the members involved. Since illness, particularly cancer, tends to isolate individuals in both their thought processes and in their relationships with others, the care and support in return can be of utmost importance both to the patient and to the family. These individuals often have difficulty in relating their true feelings to either family or friends and therefore seem to have increased emotional stress due to these limitations. The ability to share these feelings with others who have similar problems and feelings is enhanced through Make Today Count.

Participants determine the format of each meeting, the topics discussed, and the questions asked. The concern and support of the group go beyond the monthly meetings, however. They support each other when there is a recurrence or change in treatment modality. Some serve on advisory boards for cancer programs and as volunteers for the American Cancer Society. Together these people are learning to live with

their chronic disease, not in spite of it. When one of them dies, they recognize, in their togetherness, that death is also a part of life.

This group also provides learning opportunities through the use of books, tapes, games, films, and guest speakers. Topics covered include learning about disease, coping with daily health problems, communicating with others, learning to like yourself, learning to live within limits, and learning about other community resources that can help. The benefits to members are to reduce anxiety levels, to find a fuller meaning in life, and to increase in knowledge about their respective life-threatening illnesses.

The organization believes that patients with life-threatening diseases other than cancer can also benefit from Make Today Count, and solicits the support of physicians and other health care providers. Since the concept of multidisciplinary management of the patient has expanded to include Make Today Count, we have noticed that patients who have learned to face and accept their life-threatening illness are better able to communicate openly with their physicians.

Self-help groups fill a need not otherwise filled. Recognizing that patients are depressed, afraid, and worried about their disease and its ramifications was the motivating factor in founding the original Make Today Count group. A cancer

Ms. Gibson is Kent and Sussex County Nurse Coordinator, Delaware Cancer Network.

Ms. Hatfield is Oncology Resource Nurse, Delaware Cancer Network.

*An NCI-supported agency located at 1200 Jefferson Street, Wilmington, Delaware 19801. Tel. (302) 428-2113.

Cancer Communique

patient named Orville E. Kelley from Burlington, Iowa, realized that the way he was living after being diagnosed with cancer was destroying his relationship with his family. They were no longer communicating, and they were all miserably unhappy. Each was trying to cope privately, not wanting to further burden the other. Mr. Kelley realized that the only way to deal with feelings was to bring them into the open. When he finally did just that, he discovered his family was feeling very much the same as he. After he and his wife and four children were able to face directly the threat of cancer and draw strength from each other, they included others who quickly responded to the opportunity to openly discuss their feelings. The idea of self-help caught on and led to the establishment of Make Today Count, Inc. This was in 1974, and today there are over 131 chapters nationally.

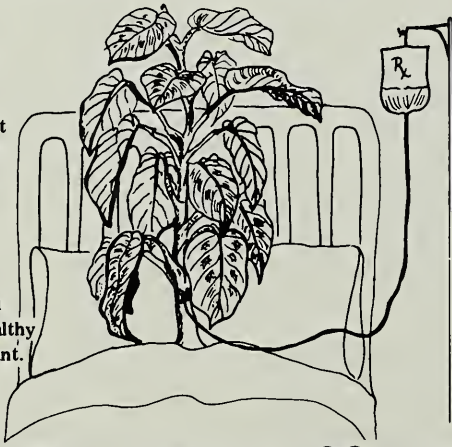
Self-help groups gain respectability and community visibility when they are affiliated with a professional agency. For this reason both the Delaware Cancer Network and the American Cancer Society, Delaware Division, support the two Delaware chapters of Make Today Count with physicians, nurses, chaplains, and social workers.

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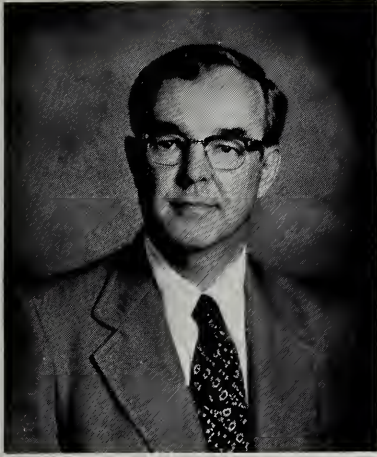
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November 1977

EDO 148P



President's Page

SELF-HEALTH MONTH

We know that with self-discipline through exercise, diet, restraint, and certain forms of abstinence, the normal human being can enjoy a longer and healthier life.

We therefore believe it appropriate for the Medical Society of Delaware to advise people to take good care of themselves.

In keeping with that belief, we have asked Governor duPont to designate June as "Self-Health Month" and to join with us in launching a widespread communications effort to encourage Delawareans to avoid those indulgences and excesses which could possibly lead to physical complications and disease.

Without going into detail regarding items or behavior to be avoided, on the grounds that mature people usually know what is harmful to them, we are undertaking a broad effort to reach our fellow citizens with this theme:

"Your Body—Abuse It; You'll Lose It."

The slogan will be carried on billboards, over the radio, and in various areas of the news media. There will be public service programs and messages with doctors and various state officials plugging the theme, all designed to awaken Delawareans to the dangers of over-indulgence and a lifelong pattern of excess and bad habits.

Posters and bumper stickers are being prepared which will be forwarded to you from the Medical Society of Delaware offices. Put the posters where your patients can see them; encourage others to use the bumper stickers and join us in June in plugging the slogan:

"Your Body—Abuse It; You'll Lose It."

John J. Egan, M.D.



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cies with proven health improvement programs and services just waiting to help people. Chances are, you know most of them — chances are, you helped develop some of them.

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THE ROLE OF LAPAROSCOPY IN INTRA-ABDOMINAL DIAGNOSIS

JOHN M. LEVINSON, M.D.

Only a decade ago most physicians had never heard of a laparoscope; few had ever seen one. Only a handful of gynecologists throughout the world could perform the procedure. In 1967, Steptoe of England published the classic text *Laparoscopy in Gynecology*.¹ Utilizing the basic Steptoe technique for tubal electro-sterilization, Wheelless in 1969 demonstrated the practicality of laparoscopy under local anesthesia.² Just six years ago, Wheelless demonstrated and taught the technique to Kanti Giri in Nepal.³ Since then, the United States Agency for International Development (USAID) sponsored projects by the Association for Voluntary Sterilization (AVS), International Fertility Research Program (IFRP), Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO), and others have put hundreds of laparoscopes in hospitals in Asia, and many, many hundreds of gynecologists have been trained in outpatient sterilization and the use of the laparoscope for infertility diagnosis and treatment.⁴ In addition to its gynecologic uses, laparoscopy has a role in intra-abdominal diagnosis.

Dr. Levinson, a gynecologist, is Southeast Asian Consultant, Program for International Education in Gynecology and Obstetrics, Johns Hopkins University School of Medicine, Baltimore.

This was adapted from a paper presented by Dr. Levinson to the Seventh Congress of the Asian Federation of Obstetrics and Gynecology in Bangkok, Thailand, in November 1977.

In 1955, a general surgeon described his experience and the detailed technique of peritoneoscopy (laparoscopy),⁵ and together with Nurick he reported a series of 136 cases.⁶ They were primarily interested in the examination of the liver, parietal peritoneum, omentum, gallbladder, and stomach. Since 1965 well over 1000 articles relating to laparoscopy have appeared in the world medical literature.⁷ Most concern sterilization, and few in the North American medical literature deal with non-gynecological problems.

From March 15, 1971 through November 15, 1977, I performed 1403 laparoscopies in the USA. In this series, 1161 were done primarily for sterilization, 123 for evaluation of infertility or primary gynecological disease, and 117 for intra-abdominal diagnosis. Additional experience has been gained in the teaching, performing, and assisting in over 350 laparoscopies in Cambodia, Indonesia, Malaysia, South Vietnam, Thailand, and in the United States.

Patient Selection

Poor risk patients were frequently encountered, but none were denied laparoscopy. (It must be noted that generalized peritonitis and acute intestinal obstruction are contraindications to the procedure).⁸

Anesthesia

The same basic techniques of local or general anesthesia used in conventional gynecological laparoscopy were utilized. (Figure 1) Endotracheal intubation was frequently used in elderly or poor risk patients.

Surgical Approach

A systematic scanning of the abdominal cavity may be done in a matter of a few minutes.⁹ Frequently the operative laparoscope is adequate without the need for a second incision for a probe. Following pelvic assessment, the operating table should be flattened while one observes the mid abdomen. Upper abdominal viewing is facilitated by 10 degree reverse Trendelenberg position. Kneeling between the patient's legs during upper abdominal viewing is particularly helpful. The operating table may be tilted laterally as needed. (Figure 2)

The appendix, the large and small bowel, large areas of the stomach, and anterior surfaces of right and left lobes of the liver can be visualized. If the gallbladder is hidden, a probe to elevate the inferior surface of the right lobe of the liver usually affords a good view of this organ. The inferior surface of the diaphragm and the lateral and anterior peritoneal surfaces are easily inspected. Splenomegaly can be detected and the omentum appraised. With experience, one can recognize changes in the falciform ligament

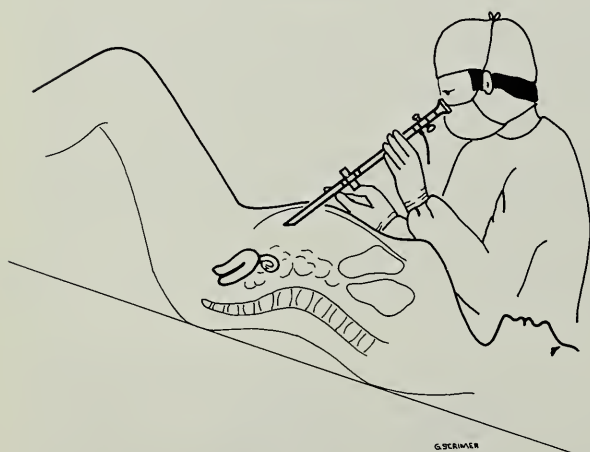
which indicate portal hypertension, and can identify the fatty or cirrhotic liver. The gross liver changes in cirrhosis are apparent; metastatic liver nodules or changes in the hepatic contour can be identified for percutaneous liver biopsy under laparoscopic guidance. (Figure 3) Biopsy should be obtained without electro-surgical technique because it causes tissue distortion that might interfere with histological evaluation, but coagulation may be employed after the biopsy has been obtained.

Despite its location in the retroperitoneal space, the pancreas, in most cases, is accessible to examination and biopsy.¹⁰ Peritoneal surfaces are easily biopsied, adhesions noted, assessed, and resected. The presence of ascites or large intra-abdominal tumors need not hinder the skilled laparoscopist. (Figure 4) The basic technique of abdominal examination may be practiced and perfected at the time of laparoscopic sterilization; not infrequently, unsuspected disease will be found.

In acute or chronic pain felt to be of gynecological origin, laparoscopy to visualize the pathology, biopsy and fulgurate areas of endometriosis, aspirate simple unilocular cysts and diagnose and obtain cultures in cases of acute pelvic inflammatory disease is often the key to treatment. Frequently laparotomy may be avoided because laparoscopy is performed.

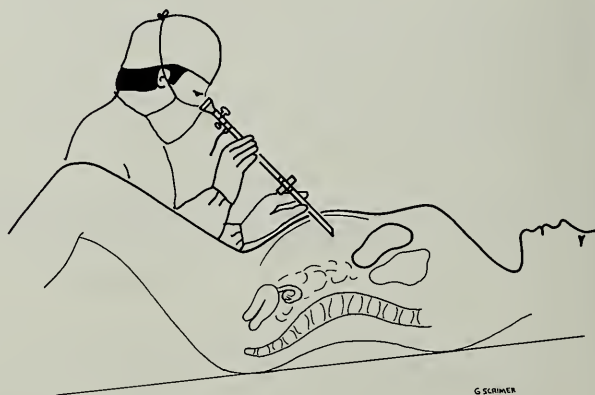
In many cases of acute or chronic abdominal pain with or without pelvic complaints or find-

FIGURE 1



CONVENTIONAL PELVIC LAPAROSCOPY

FIGURE 2



UPPER ABDOMINAL LAPAROSCOPY

ings, the clinical picture may be far from clear. Laparoscopy in these patients may avoid laparotomies and costly delays in "watchful waiting."

Acute Abdominal Pain

Hematoperitoneum Ruptured ectopic pregnancy and ruptured corpus luteum frequently present similar clinical pictures. Culdecentesis is not always positive and, even if positive, fails to indicate the correct operative approach.

In my series three cases of ruptured corpora lutea were treated by laparoscopic aspiration of the hematoperitoneum; in one case, over 300cc of blood was removed. Simply washing the bleeding site with saline disclosed that the bleeding had stopped; laparotomy was avoided in all three.

Sometimes ruptured ectopic pregnancies may be removed by laparoscopy. On occasion, retrograde menstruation may cause hematoperitoneum.

Strangulated pedunculated ovarian cysts Severe acute lower abdominal pain may be caused by a strangulated pedunculated ovarian cyst. If gangrene of the cyst has not occurred, one may attempt to untwist the pedicle. Otherwise excision and removal through the laparoscopic sleeve can be done. One patient with this problem was seen in my series.

Acute salpingitis vs acute appendicitis Prompt diagnosis and culture lead to effective antibiotic treatment; the dangers of missing acute appendi-

citis are avoided and hospital stay shortened.

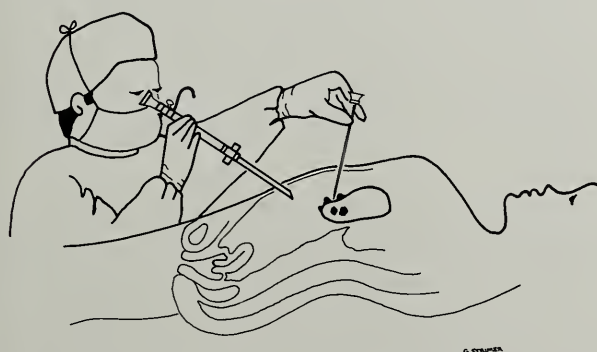
In most cases of abdominal exploration, the appendix may be located with ease by laparoscopy. A second incision for introducing a probe or second grasping forceps facilitates the procedure. Immediate laparotomy for acute appendicitis can then be done. There are reports of a suction probe being used to bring the appendix up to the abdominal wall with subsequent enlargement of the incision and appendectomy performed. In my two cases of acute appendicitis, I performed conventional laparotomy and appendectomy.

Post-operative hemorrhage Laparoscopic evaluation may disclose that bleeding has ceased and aspiration of the blood is all that is required.

Intestinal obstruction This disorder may clinically present in an atypical fashion. Sometimes electrical scissors with or without cautery can divide the adhesive bands and allow intestinal release.

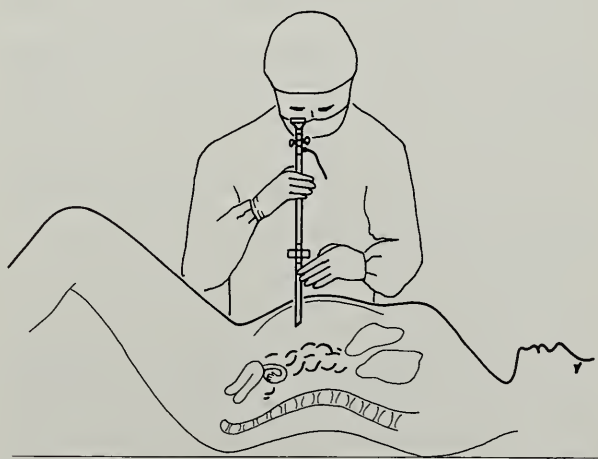
Blunt and penetrating abdominal injuries Laparoscopy is infrequently utilized in the evaluation of the extent of acute abdominal injuries. Gazzaniga and Bartlett reported on laparoscopy performed on 37 patients selected from the 132 consecutively seen patients with blunt or penetrating injuries to the anterior abdominal wall.⁴ Their use of the laparoscope to evaluate pene-

FIGURE 3



PERCUTANEOUS LIVER BIOPSY
UNDER LAPAROSCOPIC GUIDANCE

FIGURE 4



MID ABDOMINAL LAPAROSCOPY

trating abdominal wall trauma was stimulated by the number of negative laparotomies for this condition at their institution prior to the use of the laparoscope, as well as similar reports in the literature. The main limitations of laparoscopy in their series were in the evaluation of penetrating injuries and the inability to evaluate the entire bowel and retroperitoneum. In cases of blunt trauma laparoscopy had several advantages such as avoiding unnecessary laparotomy and thus saving a patient with multiple injuries from further diagnostic risks. In their total series of 37 cases there was only one falsely negative laparoscopy, and no complications related to the procedure.⁴

Acute abdominal pain, etiology unknown Many cases of dramatic onset and obscure etiology may "force the surgeon's hand." Typical examples are suspected gastrointestinal perforation or mesenteric embolism with infarction of the bowel.

A dramatic example in my series was that of a 57-year-old male with rheumatic heart disease, chronic atrial fibrillation, subacute bacterial endocarditis, and acute pulmonary edema. He was seen in Intensive Care because both the medical and surgical consultants felt this critical patient might have had mesenteric embolism with bowel infarction. His prognosis for recovery from surgical laparotomy was felt to be very poor. Laparoscopy under local anesthesia revealed normal findings. This important "negative laparoscopy" was possibly life-saving, allowing the patient to recover with medical treatment alone.

One case of "acute ileitis" was diagnosed and followed by an internist with proper medical care.

Many cases of acute abdominal pain might be properly and promptly diagnosed with more liberal use of laparoscopy.

Chronic or Recurrent Abdominal Pain

Historically exploratory laparotomy for chronic or recurrent abdominal pain has been the procedure of last recourse after non-invasive techniques for diagnosis and conservative methods of therapy have failed. Many surgeons, realizing the frequency of functional disorders as an eti-

ology for chronic or recurrent pain, understandably become reluctant to perform laparotomy.

Ideally, a multidisciplinary cooperative approach will provide the proper diagnosis in most cases so that surgery is performed only when necessary, but for reasons of time and expense, (and in many locales, lack of appropriate specialists), this cannot always be done. Laparoscopy provides a significant way of making a definitive diagnosis with conservation of time and medical resources.

Irritable colon syndrome Nineteen patients with recurrent lower abdominal and pelvic pain underwent diagnostic laparoscopy. In none was significant pelvic pathology encountered, but in some there was hyperemia of the peritoneum of the colon or small bowel. Ten of these patients had been previously diagnosed as having chronic PID; a full GI work-up resulted in a definitive GI diagnosis in every case. When proper treatment was instituted, symptoms were relieved or eliminated.

Psychiatric abdominal pain Of the 12 patients in this group, most had had GI studies with negative findings. One 16-year-old girl was certain that she had "cancer of the ovary"; her mother had died of carcinoma of the ovary. Following negative laparoscopy and reassurance, her pain disappeared. Varicosities of the broad ligaments were seen frequently in this group. In many there was distinct hyperemia of the peritoneum of the pouch of Douglas. Most patients had a decrease in their pain syndromes for many months following laparoscopy; in some, pain is no longer a complaint. Recently, laparoscopy for diagnosis and treatment of abdominal pain in adolescent girls has been advised.¹¹ The experience at the Montefiore Hospital and Medical Center in New York in fifty patients parallels mine.

Adhesions Adhesions and bands comprise a large number of cases in any series of intestinal obstruction. The causes of adhesions are diverse and not always known. They may be congenital as a consequence of external blunt trauma, following intraperitoneal hemorrhage, after inflammation of all varieties, or related to tumor in the abdomen. Their occurrence after abdominal sur-

gery for any cause is common. Christopher's textbook of surgery (1972) states "adhesions may produce symptoms other than those of intestinal obstruction but this happens rarely and such a diagnosis should be made with reservation." Laparotomy for lysis of adhesions as treatment for abdominal pain not related to intestinal obstruction has been frowned upon by the surgical community for many decades; however, I believe there are patients whose chronic or recurrent abdominal pain is due to adhesions. Laparoscopic lysis of their adhesions can be rewarding. In my series thirteen patients had as their only significant finding adhesions. In six the vascularity due to large omental adhesions precluded the resection of all or part of the adhesions. Whenever possible they were removed, often with dramatic results. One 48-year-old woman had had a hysterectomy five years previously. Three years later she began to have crampy upper abdominal pain often occurring with sexual relations. For three months prior to laparoscopy she had severe and almost constant pain in her upper mid abdomen. Medical evaluation and GI studies failed to reveal a cause for her pain. Laparoscopy disclosed a six-inch band of adhesions from the small bowel to the anterior parietal peritoneum. Following their excision with electrical scissors, the patient has remained free of pain for over three years.

Many adhesions may be innocuous, but resection seems appropriate when resectible adhesions anatomically correlate with the patient's pain.

Endometriosis Many patients with infertility or suspected gynecological disease will prove to have endometriosis. They are excluded from this discussion. However, five patients in this series were found unexpectedly at laparoscopy to have endometriosis. All presented with lower abdominal discomfort. None were associated with abnormal bleeding. Uterosacral ligament denervation performed at laparoscopy has largely eliminated the discomfort in one patient; hormonal therapy and/or definitive surgery has relieved the others. One particularly interesting patient had endometriosis of the appendix found at laparoscopy; her pain was relieved by subsequent appendectomy.

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Chronic pelvic inflammatory disease Pelvic inflammatory disease may be confused with endometriosis or spastic disease of the gastrointestinal tract. Seven cases of chronic PID were diagnosed by laparoscopy; four of these underwent subsequent pelvic surgery with relief of their symptoms.

Chronic appendicitis One patient who had had three weeks of intensive medical study and surgical consultation which had failed to reveal the cause of fever and abdominal pain was found to have a pelvic abscess due to appendicitis. Laparoscopy, which clarified the diagnosis, has been done only as a last resort.

Two other cases of "chronic appendicitis" were referred after complete GI study. These patients were found to have multiple adhesions about the appendix by laparoscopy. Subsequent appendectomy has completely relieved both of them of their pain for one and two years respectively.

In reviewing the many cases of chronic abdominal or pelvic pain that I have laparoscoped, the overwhelming majority had significant or-

ganic disease. Physical examination and non-invasive diagnostic techniques have limitations. Functional disease should not be diagnosed until organic disease has been excluded. When the correct diagnosis is made, a suffering patient may be effectively treated.

Laparoscopy in Malignant Hepatic and Biliary Tract Disease

The diagnosis of intra-abdominal cancer always involves a careful study of the liver.

In spite of the early work of Ruddock,¹² the American medical literature, compared with the European, reflects a lack of enthusiasm for oncological laparoscopy. Non-invasive techniques in the diagnosis of intra-abdominal cancer are expensive and time-consuming, particularly since the clinician is searching for histologic proof of a disease process. Even poor risk patients may be laparoscoped under local anesthesia with gratifying results.

The indications for oncologic laparoscopy are multiple. They include: suspicion of intra-abdominal malignancy; staging of intra-abdominal malignancy, such as Hodgkin's disease, to determine the extent of therapy; planning oncologic surgery, such as exploring for metastatic disease so that a patient might undergo colostomy rather than en bloc abdominal-perineal resection for carcinoma of the rectum; screening of metastases in diseases such as esophageal carcinoma; "second look" procedures in diseases such as carcinoma of the ovary; and assessment of chemotherapy.

The laparoscopist must know how and where to look and how to appropriately biopsy, must be prepared to remove large amounts of ascitic fluid and carefully study the abdominal cavity, and must understand the goals and the risks involved. A higher rate of complications in laparoscopy of this type than in simple laparoscopic tubal sterilization is well documented.¹³ Skill with local anesthesia is important. Percutaneous biopsies with laparoscopic visualization may be more prudent and provide more information than biopsy through the laparoscope alone. Tissues should not be coagulated until after biopsying in order to prevent histologic distortion. Biopsies are contraindicated in he-

mangiomatous lesions because of bleeding problems. The risk of pleural rupture exists in any case of subdiaphragmatic biopsy. Proximity of the great vessels necessitates extreme caution when biopsying the pancreas and retroperitoneal nodes.

Gynecological Cancer

Carcinoma of the cervix One patient in my series had been treated six years previously with radiation therapy for stage I-a squamous cell carcinoma of the uterine cervix. Subsequently she developed severe pain, dyspareunia, and bleeding. After a laparoscopy in which nothing abnormal was noted, she underwent hysterectomy and has been asymptomatic for two and a half years.

Carcinoma of the endometrium One patient three years after radiation and hysterectomy for carcinoma of the endometrium presented with abnormal liver function studies but a normal liver scan. Multiple percutaneous liver biopsies under laparoscopic guidance disclosed a fatty liver.

A second patient with carcinoma of the endometrium following radiation therapy underwent a hysterectomy. Routine upper abdominal exploration revealed a small vascular lesion on the right lobe of the liver and a small nodularity that was suspect of being a tumor. No further information could be obtained at the time of hysterectomy because of her poor risk status and obesity. One month later, after a negative CAT scan but a positive liver scan, liver biopsies under laparoscopy guidance were performed which disclosed fatty change. Three months later, a repeat liver scan was unchanged as were repeat laparoscopy and liver biopsies. The patient has now gone for 14 months with no further hint of metastatic disease.

Carcinoma of ovary Frangenheim and Stockhammer reported 218 laparoscopies performed for pelvic mass in postmenopausal patients.¹⁴ In 64% of the patients laparoscopy obviated the need for laparotomy, because of the finding of either inoperable malignancy or benign disease. In my series, excluding infertility patients and those suspected of having endometriosis, 14 patients have been studied because of suspected or known ovarian tumor. Three patients had

unilocular tumors that could not be aspirated and immediately underwent laparotomy for cystic teratoma. One struma ovarii and one adult teratoma were discovered as an incidental finding at laparoscopic sterilization. Four simple unilocular cysts in patients under 35 years of age were aspirated and have not recurred. One suspected solid tumor of the ovary was found to be a pedunculated fibroid. Two patients with metastatic ovarian carcinoma were spared further surgery because the diagnosis was obtained at laparoscopy with ovarian biopsy. Two additional patients with adenocarcinoma of the ovary have each undergone two "second look laparoscopies."

Liver biopsies, biopsies of suspicious areas of the peritoneum, and intra-abdominal washings with saline and study for tumor cells can be done routinely by laparoscope. Laparoscopy also affords the opportunity to insert a catheter across the upper abdomen to instill radioactive P-32 for better isotopic distribution.¹⁵

Whether and when one should undergo laparoscopy following treatment for ovarian carcinoma remain questionable. It appears that laparoscopic examinations can spare some patients a second look laparotomy and yet provide a safe assessment of intra-abdominal disease. If residual tumor is not found at laparoscopy, however, some authorities feel that laparotomy with multiple peritoneal biopsies must be done so that the residual tumor will not be missed and chemotherapy prematurely stopped. They do not consider laparoscopy an alternative to "second look" laparotomy, but a useful adjunct for determining the presence of resectable, nonresectable, or diffuse disease after chemotherapy.¹⁶

One patient was referred with a carcinoid tumor of the left supraclavicular node. Her primary lesion was diagnosed by biopsying a 5mm nodule on the left ovary.

Carcinoma of the breast In the United States cancer of the breast occurs two times more often than cancer of the cervix and uterus combined.¹⁷ It is the leading cause of cancer deaths in females in our country. Metastatic disease to the liver, ovary, and GI tract is common. Definitive studies as to the place of laparoscopy in diag-

nosing and staging advanced disease and its role with chemotherapy must be undertaken.

Two patients in my series underwent laparoscopy to rule out intra-abdominal spread of disease. The "psychological boost" of negative findings to these individuals was most rewarding.

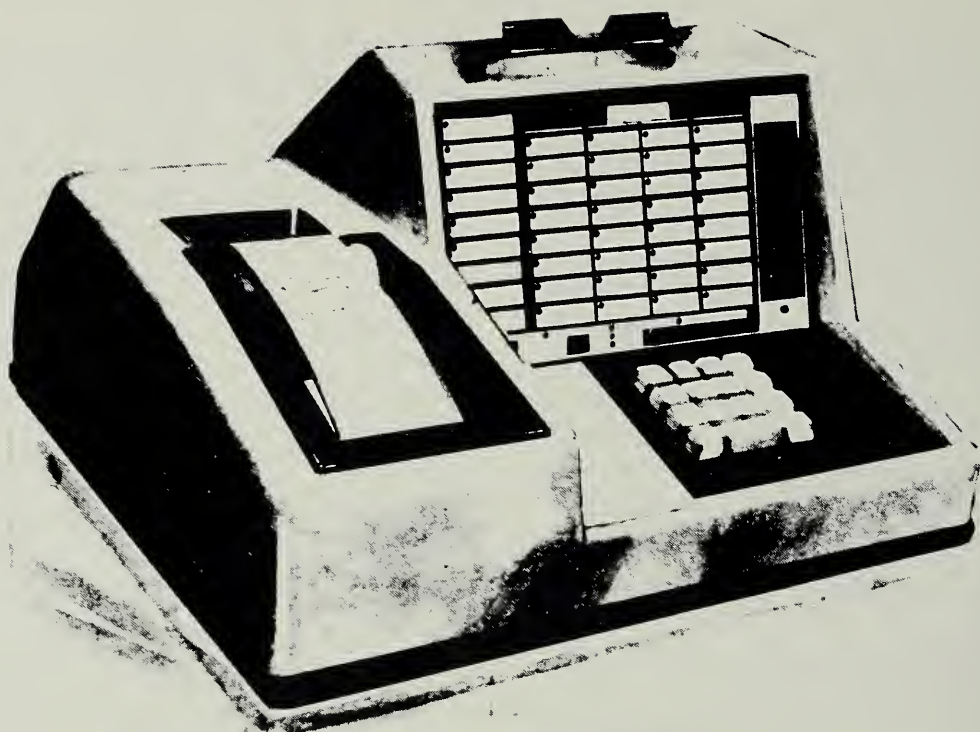
Carcinoma of the gastrointestinal tract This is one of the most challenging diagnoses in abdominal laparoscopy. One must know the site of the primary lesion and the site and extent of metastasis, if present. A liver scan prior to laparoscopy is recommended. Sauer reports 123 patients with primary or metastatic liver tumors who were subjected to both liver scan and laparoscopy. The findings were verified by biopsy, operation, or autopsy.¹⁸ Liver scan failed to reveal the tumor in 21%. Laparoscopy on the basis of gross appearance alone missed 34%, but with biopsy under laparoscopic guidance, only 20% were missed. By the systematic use of both liver scan and laparoscopy with directed liver biopsy, diagnostic accuracy was increased to 93%. No false positive cases resulted from laparoscopy.

Liver scan has limitations in that it does *not* distinguish between benign and malignant lesions, lesions on the surface of the liver must be at least 2cm in diameter and deeply located ones must be almost 4cm in diameter to be detected, and the interpretation of the liver scan may be misleading because of variations in the anatomy of the liver.

Laparoscopy has limitations in that large areas of the liver cannot be viewed by the laparoscope, lesions completely within the liver cannot be visualized, and it is an invasive procedure.

It is apparent that the two techniques are complementary. A liver scan is recommended before laparoscopy and liver biopsy. In the presence of clinically suspected diffuse liver disease, however, laparoscopy with directed biopsy is more useful and reliable than a liver scan.

In the 41 cases in which I performed liver biopsies with laparoscopy, I have learned that biopsying directly with operating forceps through the laparoscope is cumbersome and may cause



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excessive bleeding. Frequently the lesion cannot be reached. The biopsy is preferably made with a Vim-Silverman needle or the Travenal Company disposable biopsy needle used percutaneously under direct laparoscopic guidance. Multiple biopsies should be made of both the left and the right lobes of the liver unless obvious nodules can be directly biopsied. Experience enables visual differentiation between an advanced cirrhotic liver and one with advanced metastatic disease and in the perception of subtle changes in contours in the liver which may indicate an underlying tumor mass. One patient with an adenocarcinoma of the colon had grossly normal liver. Two random biopsies were normal via laparoscopy. Only ten days later a surgical laparotomy disclosed miliary metastatic lesions on the liver surface. One additional patient with negative findings by laparoscopy underwent a surgical laparotomy. By palpation of the liver deep nodule was located; biopsies disclosed metastatic carcinoma.

In my experience, I have frequently been called to help in the diagnosis only after days of exhaustive and expensive study of a chronically ill patient. In nine of these patients various types of cirrhosis of the liver have been the diagnoses. In one 40-year-old male an advanced case of biliary cirrhosis was encountered. By the time the diagnosis was made, the patient's condition had deteriorated so that he did not survive definitive surgery.

Carcinoma of the rectum Sotnikov and Agamov reported 37 cases of carcinoma of the rectum where routine laparoscopy performed preoperatively disclosed eight patients to have metastatic disease.¹⁹ This preoperative survey permitted a determination of the extent of the disease, and hence appropriate therapy could be undertaken. In my series one patient who the general surgeon felt had carcinoma of the ovary, a preoperative laparoscopy revealed a retroperitoneal pelvic mass with a 3mm nodule on the left uterosacral ligament, which on biopsy proved to be metastatic adenocarcinoma of the rectum. Following appropriate preparation the general surgeon performed a definitive procedure.

Carcinoma of the pancreas Meyer-Burg et al reported their ability to visualize part of the

pancreatic body in 81 or 65% of 125 patients.²⁰ In 15 of the 81, carcinoma of the pancreas was diagnosed. Part of their technique was to elevate the head of the operating table and place the patient in the right lateral decubitus position. The rounded tip of the laparoscope or the probe was used to elevate the left lobe of the liver. Needle biopsies of the pancreas were obtained under direct vision.^{10,20} This technique, however, only allows visualization of part of the pancreatic body. I have no familiarity with this technique, but I urge that all interested in intra-abdominal diagnosis by laparoscopy, study the technique, return to our anatomy textbooks and to the autopsy table, and then carefully assess use of the procedure by trial at the time of diagnostic laparoscopies.

Carcinoma of the esophagus Sotnikov advocates the routine use of laparoscopy to determine whether there is intra-abdominal metastasis.²¹ In 16 of 65 patients by laparoscopy he found metastases of the liver, parietal peritoneum, lymph nodes of the lesser omentum, bowel, or

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other organs. In general, the lower the esophageal lesion was, the greater the chance of finding intra-abdominal metastases. Diagnosis by laparoscope offers a choice of definitive or palliative surgery, or conservative treatment, based upon knowledge of the extent of the disease process.

Hodgkin's Disease Detailed studies to determine the extent of the disease are currently recommended prior to instituting therapy. Generally it is felt that hepatic involvement occurs in the latter stages of the disease. A study undertaken at the National Cancer Institute assessed laparotomy versus laparoscopy as a staging procedure. It was concluded that evaluation of the liver by a sequence of percutaneous liver biopsies and needle biopsies via laparoscopy revealed hepatic involvement as often as conventional wedge biopsy of the liver at laparotomy.²² Spinelli showed that splenic puncture can be accomplished by laparoscopy;²³ however, if negative, splenectomy is usually recommended. Two patients in my series were staged for Hodgkin's, but splenic puncture was not attempted because of non-visualability of the spleen.

Laparoscopy as a diagnostic study in non-Hodgkin's lymphoma is not routinely advocated because the false negative rate has been found to be 50% compared with laparotomy.²³

Enthusiasm for laparoscopy in oncology must not overwhelm one's good clinical judgment. One cachectic elderly man, several months post-operative from an esophageal resection for carcinoma, was seen with a 10cm mass in the lower abdomen. I rejected laparoscopy since I felt that metastatic disease was apparent and that biopsying what was probably a large vascular lesion would be too hazardous. Another patient had extremely vascular lesions on her omentum that I felt could not be safely biopsied. I visualized them via laparoscope. A minilaparotomy followed during which metastatic bladder carcinoma was found. Another individual with numerous previous laparotomies had been treated with chemotherapy for a malignant mesothelioma of the peritoneum. An "open laparoscopy" was done; visualization was poor, but a small peritoneal and omental biopsy revealed recurrent tumor. This provided the information that was needed for chemotherapy to be reinstituted.

Conclusion

In less than a decade gynecologists throughout the world have embraced laparoscopy as an effective and safe method for female sterilization. The technique is gaining wide acceptance in gynecological diagnosis and as an integral part of the infertility study. As yet there has been only sporadic interest in the tremendous potential for laparoscopy in the diagnosis of acute and chronic abdominal pain, in intra-abdominal study following trauma, and as an aid in diagnosis and staging of intra-abdominal malignancy. In experienced hands laparoscopy is a safe and effective method of reaching a prompt diagnosis at a great saving in time and expense to the patient. Therapy can be planned and unnecessary surgical procedures avoided. Considerable study will be necessary for us to define its place in "second look procedures" and in other types of intra-abdominal diagnoses.

REFERENCES

1. Steptoe PC: Laparoscopy in Gynaecology. Edinburgh, E & S Livingston Ltd, 1967.
2. Wheeler CR: A rapid, inexpensive method of surgical sterilization by laparoscopy. *J Reprod Med* 3:65, 1969.
3. Levinson JM: Laparoscopy sterilization programs in Asia. *Asian Med J* 9:121, 1973.
4. Phillips JM, Carson SL, Keith L, Levinson CJ, Yuzpe AA: Laparoscopy, Baltimore, The Williams and Wilkins Company, 1977.
5. Handley RS: *Postgrad Med J* 31:81, 1955.
6. Handley RS, Nurick AW: *Br Med J* 11:1211, 1956.
7. Phillips JM: Laparoscopy A Bibliography 1965-1975.
8. Levinson JM: Laparoscopy—a review of 325 consecutive private cases. *DSMJ* 45:3, 1973.
9. Levinson JM: The non-gynecological use of the laparoscope. *J Reprod Med* 15:2, 1975.
10. Meyer-Burg J: The inspection, palpation and biopsy of the pancreas by peritoneoscopy. *Endoscopy* 4:99, 1972.
11. Kleinhaus S, Hein K, Sheran M, Boley SJ: Laparoscopy for diagnosis and treatment of abdominal pain in adolescent girls. *Arch Surg* 112:1178, 1977.
12. Ruddock JC: Peritoneoscopy. *Southern Surgeon* 8:113, 1939.
13. Phillips J, Keith D, Keith L, Hulka J, Hulka B: Survey of gynecologic laparoscopy for 1974. *J Reprod Med* 15:45, 1975.
14. Frangenheim J, Stockhammer H: Fa laparoscopie dans le diagnostic—différential des tumeurs du petit bassin chez les femmes ménopausées. *Gynaecologia* 167:503, 1969.
15. Cope JL, Gormel V: Laparoscopy in the treatment of early ovarian malignancy (unpublished data).
16. Smith GW, Day TG, Smith JP: The use of laparoscopy to determine the results of chemotherapy in ovarian cancer. *J Reprod Med* 18:275, 1977.
17. Haagensen CD: *Disease of the Breast*. Philadelphia, WB Saunders Co, 1971.
18. Sauer R, Fahrlander H, Fridrich R: Comparison of the accuracy of liver scans and peritoneoscopy in benign and malignant primary and metastatic tumors of the liver. *Scand J Gastroenterol* 8:389, 1973.
19. Sotnikov VN, Agamov AG: Laparoscopic diagnosis of intra-abdominal metastases in cancer of the rectum. *Sov Med* 10: 108, 1974.
20. Meyer-Burg J, Ziegler U, Palme G: Zur supragastralem pankreaskopie. *Dtsch Med Wochensche* 97: 1969, 1972.
21. Sotnikov VN, Evmolov AS, Litvinov VI, Emeljanov SS, Samsonov VS: The diagnosis of intra-abdominal metastases of esophageal cancer by means of laparoscopy. *Vopr Onkol* 19:38, 1973.
22. Bagley CM, Thomas LB, Johnson RE, Chretien PB, DeVita VT: Diagnosis of liver involvement by lymphoma: results in 96 consecutive peritoneoscopies. *Cancer* 31:840, 1973.
23. Spinelli P, Beretta G, Bajetta E, Tancini G, Castellani R, Rilke F, Bouadonna G: Laparoscopy and laparotomy combined with bone marrow biopsy in staging Hodgkin's disease. *Br Med J* 4:554, 1975.

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BECLOMETHASONE DIPROPIONATE AEROSOL THERAPY IN OBSTRUCTIVE LUNG DISEASE

JAMES M. HOFFORD, M.D.
ANN S. DOWLING, PuT.

Beclomethasone (*Vanceril*-Schering) is a steroid aerosol marketed for the treatment of bronchial asthma. This agent does not have the systemic effects usually encountered when steroids are administered by mouth, an obvious advantage in terms of long-term treatment of asthmatic patients. It is stated to be of use only in patients with bronchial asthma. In practice, however, it is often difficult to distinguish pure asthma from other forms of obstructive lung disease, and physicians often prescribe beclomethasone dipropionate aerosol (BCMA) for patients having reversible bronchospasm due to obstructive lung disease other than pure asthma. This study was undertaken to evaluate its effect in patients with reversible bronchospasm, regardless of etiology.

Methods

The patients studied were selected from the private practice of the author. All had stabilized clinically. Drug therapy at the time of the patient's entry into the study included IPPB, bronchodilators, antibiotics, steroids, and desensitization.

Patients who had reversible bronchospasm were selected for study. The group included 27 patients with asthma and nine with bronchitis-emphysema. Reversible bronchospasm was defined as the presence of wheezing on auscultation and improvement in pulmonary function

after isoproterenol (*Isuprel*, Winthrop). Thirty-six patients were studied initially.

Pulmonary function studies and clinical evaluation were performed initially. The beclomethasone, two inhalations QID, was then prescribed. Follow-up evaluation was made six weeks after beclomethasone aerosol was begun.

Table 1 summarizes the pulmonary function findings before and after *Isuprel* aerosol selected in the 36 patients included in this study. The

TABLE 1
PULMONARY FUNCTION BEFORE AND
AFTER ISOPROTERENOL

Average of 27 patients with asthma and nine
with bronchitis-emphysema

	Asthma	Bronchitis- Emphysema
Vital Capacity (cc)		
Before <i>Isuprel</i>	3110	2676
After <i>Isuprel</i>	3369	3231
Difference	259	555
Percent Change	8%	21%
Maximum Breathing Capacity (L)		
Before <i>Isuprel</i>	74	33
After <i>Isuprel</i>	94	43
Difference	20	10
Percent Change	27%	30%
Maximum Expiratory Flow Rate (L)		
Before <i>Isuprel</i>	3.2	0.8
After <i>Isuprel</i>	4.1	1.2
Difference	0.9	0.4
Percent Change	28%	50%

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degree of reversible bronchospasm potentially obtainable in these patients is seen as the percent change after Isuprel aerosol in Vital Capacity (VC), Maximum Breathing Capacity (MBC), and Maximum Expiratory Flow Rate (MEFR).

The patients were determined as having asthma or bronchitis-emphysema on the basis of clinical findings, chest x-ray, and baseline pulmonary function. Patients with emphysema usually had and FEV-1/VC ratio of less than 40% and flow volume loops demonstrating that their flow rate on expiration reached 1 liter per second or less when 30% of vital capacity had been expired. Patients with asthma usually had FEV-1/VC ratios of 40% to 70%; on their flow volume loops, flow rate of 1 liter per second was reached after the patient had expired greater than 30% of the vital capacity. Their steroid therapy was initially in most instances 10 to 20 mg of prednisone daily or every other day. No patients were receiving doses greater than 20 mg daily; all of them were told that with the beginning of beclomethasone aerosol they could gradually taper their prednisone dose.

Pulmonary function studies before and after BCMA included measurement of VC, MBC, MEFR, FEV-1, FEV-1/VC ratio before and after isoproterenol 0.5 cc (0.5%) by aerosol. The body plethysmograph was used to measure Functional Residual Capacity (FRC), Residual Volume (RV), Airway Resistance (Raw), and Total Lung Capacity (TLC).

Results

A total of 36 patients were initially included in this study. Four patients with asthma and two with bronchitis-emphysema were dropped from the study because of poor cooperation. One with asthma was dropped because of recurrent pharyngitis and candida infection and a second because of an accident which prevented his further cooperation. Thus twenty-eight patients finished the study including 21 asthmatics and seven patients with bronchitis-emphysema.

Of the 21 patients with asthma who completed the study, 19% (four) developed nasal congestion and decreased sense of smell not present while they were taking steroids. Fourteen percent (three) of 21 asthmatics and 14% (one) of

seven bronchitis-emphysema patients stopped beclomethasone because of respiratory tract irritation. Two noted less exertional asthma, and two were able to sleep without wheezing for the first time in a year.

TABLE 2
CHANGES IN PULMONARY FUNCTION BEFORE
AND AFTER BECLOMETHASONE

	Asthma	Bronchitis- Emphysema
Vital Capacity (VC, cc)		
Before Beclomethasone*	3265	2761
After Beclomethasone*	3404	2807
Difference	139	46
Percent Change	4%	2%
Maximum Breathing Capacity (MBC, cc)		
Before Beclomethasone	74	35
After Beclomethasone	90	41
Difference	16	6
Percent Change	22%	17%
Maximum Expiratory Flow Rate (MEFR, L)		
Before Beclomethasone	3.28	0.83
After Beclomethasone	3.52	0.96
Difference	0.24	0.13
Percent Change	7%	16%
FEV-1/VC		
Before Beclomethasone	57%	27%
After Beclomethasone	62%	32%
Difference	5%	5%
Functional Residual Capacity (FRC)		
Before Beclomethasone*	3792	5920
After Beclomethasone*	3616	5540
Difference	-176	-380
Percent Change	-5%	-6%
Residual Volume (RV)		
Before Beclomethasone	2907	4765
After Beclomethasone	2711	4557
Difference	-196	-208
Percent Change	-7%	-4%
Total Lung Capacity (TLC)		
Before Beclomethasone	6165	7546
After Beclomethasone	6087	7401
Difference	-78	-145
Percent Change	-1%	-2%
Airway Resistance (Raw)		
Before Beclomethasone	3.95	5.4
After Beclomethasone	2.82	4.0
Difference	-1.13	-1.4
Percent Change	-29%	-26%

*Average values of 28 patients completing the study

Table 2 summarizes the changes of pulmonary function in 28 patients. The before and after values of VC, MBC, MEFR, and FEV-1/VC represent averages for the 28 patients who completed the study. The improvement in each value is seen as the difference and percent change after BCMA.

Also shown are the average differences and percent changes in FRC, TLC, and Raw before and after BCMA.

The number of patients studied was not sufficient for statistical analysis.

The changes in VC and MEFR were small. The increases in MBC are positive and represent a considerable increase. Changes in FRC, RV, and TLC were generally in a negative direction representing less air trapping although not statistically significant. The decreases in Raw of —29% in asthma and —26% in bronchitis-emphysema are significant and correlate with the clinical improvement.

Table 3 lists the clinical data in 21 patients with asthma and seven with bronchitis-emphysema. Subjective symptoms were determined by questioning patients with regard to cough, sputum production, wheezing, and dyspnea. The objective symptoms were primarily related to auscultation of the chest for rales, wheezing, and intensity of breath sounds.

Nine of 21 patients with asthma were able to eliminate steroids from their treatment program. The remaining 12 patients decreased their steroid dose. Nine asthmatics were completely free of all symptoms subjectively and objectively after beclomethasone. Four patients with bronchitis-emphysema decreased their steroid dose, four improved subjectively, and five improved objectively.

Discussion

Beclomethasone is an aerosol steroid used in the treatment of asthma. It is dispensed as a metered dose aerosol unit containing a micro-crystalline suspension of beclomethasone dipropionate in propellants (trichlorofluoromethane and dichlorodifluoromethane) with oleic acid as a dispersing agent. Each canister contains 10 mg of beclomethasone dipropionate; each

TABLE 3
CLINICAL DATA

Patients	Weeks on Beclomethasone	Steroids	Symptoms	
			Subjective	Objective
ASTHMA				
1.	6	D 4+	B 4+	B 4+
2.	9	D 4+	B 4+	B 4+
3.	6	D 4+	B 4+	B 4+
4.	5	D 4+	B 4+	B 4+
5.	8	D 4+	B 4+	B 4+
6.	14	D	B 4+	B 4+
7.	8	D	B 4+	B 4+
8.	7	D	B 4+	B 4+
9.	12	D 4+	B	B
10.	7	D 4+	B	B
11.	7	D 4+	B	B
12.	7	O	B	B
13.	7	D	B	B
14.	9	D	B	B
15.	10	D	B	B
16.	16	D	B	B
17.	6	D	B	B
18.	33	D	B	B
19.	6	D	B	B
20.	13	D	B	B
21.	5	D 4+	B 4+	B 4+
BRONCHITIS- EMPHYSEMA				
1.	6	D	B	B
2.	7	D	B	B
3.	12	D	B	B
4.	12	D	S	B
5.	6	S	B	B
6.	7	S	S	S
7.	7	O	S	S

LEGEND

Patients Completing Study—21 Asthmatics,
7 Bronchitis-emphysema

D 4+=decreased to zero
B 4+=symptoms
disappeared
D=decreased
S=same
O=never on steroids
B=better

actuation releases 50 mcg. There are at least 200 oral inhalations in one inhaler. Thus, the average inhaler would probably last a patient approximately one month at a cost of \$11.00.

The literature states that there is no suppression of early morning cortisol levels when beclomethasone is administered in a dose of 1,000 mcg per day.¹ Partial suppression of endo-

geneous cortisol has been observed when BCMA is administered in a dose of 2,000 mcg per day given either intramuscularly or by aerosol. Immediate suppression of cortisol occurs after a single dose of 4,000 mcg.¹ The claim has been made that in the doses used clinically, this drug does not have any significant influence on cortisol production. No other metabolic side effects have been described such as purpura, osteoporosis, or peptic ulcer disease.

The long-term effects of beclomethasone on human subjects are still unknown. In studies of beagle puppies, it was found that aerosol administration was associated with a high incidence of convulsions and uncoordinated movements attributed to the fluorocarbon propellant and possible anoxia caused by the mode of administration of the aerosol. On postmortem examination, these dogs showed irregular tracheal caliber in the treated but not the control animals. In female animals, the possibility of drug-related interference with sexual maturation and function was suggested.

Beclomethasone is not indicated in the treatment of asthma that can be controlled by bronchodilators and other non-steroid medications. It is not indicated for patients who require only infrequent use of systemic steroids. The Schering Company also states that it is not indicated in the treatment of nonasthmatic bronchitis. It has been our observation, however, that many physicians in clinical practice have been tempted to try it in bronchitis-emphysema when the patient presents with reversible bronchospasm and wheezing.

Vince et al concluded that beclomethasone is of value in steroid-dependent asthmatics, but less useful in patients who have asthma and chronic bronchitis.² Lovera et al found no improvement in airway conductance in asthmatic children after the use of beclomethasone. They did demonstrate that mean values of pulmonary function moved in the direction of improvement during therapy.³

It has been carefully pointed out that adrenal insufficiency may occur when a patient is transferred from systemic steroid therapy to beclomethasone too quickly. Other allergic conditions

such as rhinitis, conjunctivitis, and eczema may be unmasked when oral steroids are eliminated.

Localized infections with *candida albicans* and *aspergillus niger* have occurred in the mouth, pharynx, and larynx following BCMA. It has been reported that up to 75% of patients who received prolonged treatment have positive oral cultures for candida but clinical infection occurs at a much lower rate.

Pulmonary function in the present study demonstrated significant improvement in MBC and Raw. The MBC increased 22% in asthma patients and 17% in bronchitis-emphysema patients. There was a marked decrease in Raw of -29% in asthma and -26% in bronchitis-emphysema. The changes in VC and MEFR were in a positive direction but small. The FRC, RV, and TLC values tended to be in a negative direction but were not significant.

Steroids were eliminated in 43% of the asthmatics after beclomethasone. The remainder were able to decrease their dose. Four of seven bronchitis-emphysema patients decreased their steroid dose.

The clinical response in 43% of the asthmatics showed complete disappearance of subjective and objective symptoms. The remainder improved. A majority of the bronchitis-emphysema patients improved clinically.

All seven of the bronchitis-emphysema patients stopped beclomethasone after completing the study because they did not believe there was sufficient improvement to warrant its continued use. This is paradoxical in view of the decrease in their steroid dose and subjective improvement in their symptoms in four of seven.

The findings in bronchitis-emphysema suggest further study is needed on a larger number of patients to see if beclomethasone will help significantly those who have reversible bronchospasm.

REFERENCES

1. Farr RS, Middleton E, Spector S: Recent Advances in Asthma Therapy. Miami, Florida, Symposia Specialists Medical Books, 1976.
2. Mintz S, Broder I, Davies G: A double-blind cross-over study of beclomethasone dipropionate in asthmatic patients with and without chronic bronchitis. *Postgrad Med J* 51:76-79, 1975.
3. Lovera J, Cooper DM, Collins-Williams C, et al: Clinical and physiological assessment of asthmatic children treated with beclomethasone dipropionate. *J Allergy Clin Immunol* 57: 112-123, 1976.

MINOR TRANQUILIZERS: ARE THEY BEING RATIONALLY PRESCRIBED?

J. THOMAS UNGERLEIDER, M.D.

Of the psychotropic medications used in the United States, the minor tranquilizers have become the most widely used and publicized. The public has received numerous alerts regarding misuse of these drugs, taken either in combination with alcohol or by themselves, in excessive, unprescribed doses as well as by prescription.

The purpose of this presentation is to explore the usage patterns of these drugs in an attempt to arrive at a philosophy of use that is rational and pragmatic, and takes into account some of the real issues and patterns of substance use and abuse in our society today.

The philosophical arena is that of taking a drug, on the one hand, to relieve dysphoria or symptomatology and, at the other end of the continuum, taking drugs for pleasure. Somewhere in the middle is the taking of drugs to "calm oneself" or to "feel better."

One noted pharmacologist takes the position that these drugs are indicated primarily when anxiety is disabling and are used as an adjunct to relaxation techniques and biofeedback.¹ Some physicians attempt to differentiate along the continuum and restrict the use of minor tranquilizers to the treatment of anxiety, including neurotic anxiety as differentiated from symptomatic anxiety, a condition which is extremely common among the adult population.

Because anxiety is an elusive and so often pervasive clinical syndrome, there are not enough psychiatrists in the country to diagnose the type of anxiety (neurotic vs situational) that is present. In addition, those who do attempt such differentiation often rely on subjective assessment and rarely observe signs such as quivering voice, wet armpits, and nervous tics.²

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It is said that one in every ten American adults takes the minor tranquilizer diazepam because of tension and nervousness, during any three-month period.³ The moral as well as the medical issue in taking any medication is extremely important and perhaps nowhere better illustrated than in the use of the minor tranquilizers. Some social commentators have expressed concern that widespread use of these mood-changing drugs indicates major undesirable changes in the American character, mainly an evidence of a general moral decline, specifically indicating "weakness."⁴ A moralistic condemnation of the evils of psychotherapeutic drug use is a recurrent theme in contemporary society, and the medical profession is often the scapegoat, particularly where there are critical aspects of this drug use which are not directly controllable, eg, illegal, overt traffic in drugs.⁵

Let us examine current patterns of drug use to dispel mythology and see how much of what is frequently stated is factually based. Rather thorough studies of tranquilizers do exist and show that, in general, Americans of disparate income, education, occupation, and sex believe that tranquilizers are effective, but have serious doubts about the morality of using them and also about their safety.⁴ There are, however, differences in attitude between those who have used psychotherapeutic drugs and those who have not, and there is a tendency towards more liberal attitudes in the West. There is also a greater likelihood for the least educated respondents to equate the use of psychotherapeutic drugs with character weakness.

It is particularly interesting to me, having spent a large part of my professional life working in the areas of substance abuse, to hear physicians pay lip service to the inadvisability of the use of any medication to "enhance a feeling of

well being," while supposedly limiting their prescribing for the purpose of decreasing dysfunctional symptoms. Although this is an attitude commonly expressed in the literature and by panels on drug abuse, privately many of these same and other physicians will describe their more widespread prescribing procedures. Time constraints and economic motives often play a part in their motivation to prescribe.

A variety of issues have been well delineated in a fascinating analysis of psychotherapeutic drug consumption in the United States.⁵ In a symposium on "The Over-Medicated Society," the possibility that the physician uses these drugs in lieu of personal attention and is unconcerned or unaware of the drug dependence potential of the drugs was considered. In addition, the value and characterological issues which have been mentioned were reiterated: people receive drug treatment when they should have more tolerance for adversity and suffering. This is best expressed by the theme that psychic illnesses are not legitimate diseases, but are merely an expression of lack of will. It is also charged that these drugs have adverse effects on motor performance and social functioning. Some proponents of these positions portray physicians as treating social pathology rather than medical illness, and claim that the drugs are being used to treat symptoms rather than diagnoses. Excessive drug production and excessive cost of these medications have been implicated as has the influence of drug advertising. These are the perceived issues; what are the facts?⁵

In the year 1972, 44% of the 215 million prescriptions for psychotherapeutic drugs in the

United States were accounted for by the anti-anxiety agents. This drug use is much more prevalent in older people. In the 60- to 74-year-old age bracket, men are four times as likely to use such drugs as men in the 18- to 29-year-old bracket.

Who prescribe these drugs? Ninety-five per cent are prescribed by non-psychiatrists. In what manner are these drugs prescribed? In a conservative manner. In 60% of the anti-anxiety agents prescribed, no refills were permitted. When they were, both the number of refills and the quantity of drugs per prescription were small.

For whom are the anti-anxiety drugs prescribed? They are prescribed for specific diagnoses of mental disorder and in only a little more than one-third of the instances of new therapy. Thus, it is more likely that anti-anxiety agents are prescribed for patients with a main diagnosis of physical disorder than for mental disorder.

What about the amount of distress for those receiving these drugs? In this particular large study, 60% of the men and 70% of the women who used these drugs experienced high scores on tests for psychic distress and life crises in the year preceding their interview, but 67% of the persons whose crisis scales were high had not used any psychotherapeutic drugs. There are additional data to show that many of those who do use these drugs are guilty and in conflict about taking this kind of medicine.

International Aspects

Nine western European countries were surveyed as to the use of anti-anxiety drugs and



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attitudes towards tranquilizers. In almost every country the percentage of females who had used anti-anxiety/sedative drugs was approximately twice that of males. Those over the age of 45 were over-represented among the users in relation to their presence in the general population. Comparing our country with these use patterns, the United States was in a middle position among the nine countries surveyed.⁶

Alternate Drug Use

Certain psychotropic substances like alcohol and marijuana, which may be substituted for tranquilizers, are much more often used by men than women. It is also worth re-emphasizing that prescription sedatives and minor tranquilizers are most prevalently used by housewives who are poor and poorly-educated rather than by well-to-do, educated women. Different groups of patients take prescription drugs from those who use over-the-counter drugs. Surprisingly, over-the-counter drugs' usage rates are *highest* among the richer and better educated rather than among the poorer and least educated.

It is also important to remember that treatment of mental diseases and better health care for previously neglected sub-groups in the population are quite likely to produce "... increases in the overall volume of drug consumption ... If the sheer ability to survive or to weather a storm of illness without drugs is the test of appropriate prescribing, or responsible patient behavior, there is obviously little need for most pharmaceuticals."⁸

Summary

There are real differences in attitudes about the minor tranquilizers involving both the prescribers and the consumers. The differences, however, are not on the issues of safety, side effects, or long-term physical consequences. Rather they are on the effects on morality, negative behavior consequences, and efficacy. Rational use of the minor tranquilizers should include awareness on the part of the prescriber of his own medical and moral biases.

There are 1.4 billion prescriptions for psychotherapeutic drugs filled each year at a cost of between 500 million and one billion dollars.⁹ It is speculative to estimate the percentage of these prescriptions which "help," but patients quickly become opinionated about what medicine helps them and demand what works while eschewing what doesn't.

Prescribers must calculate as part of their treatment equation the possibility of flagrant misuse of these medications. This includes the possibilities of patients taking truly excessive dosages or of selling their drugs to those who self-medicate or are otherwise drug dependent.

REFERENCES

1. Hollister L: Symposium of American Society of Clinical Pharmacology and Therapeutics. Clin Psy News 3:10, 1975.
2. Hollister L: The prudent use of anti-anxiety drugs. Nat Drug Therapy 6:1, 1972.
3. Greenblatt DJ, Shader RI: Drug therapy. NEJM 291:1239-1242, 1974.
4. Manheimer DI, Davidson ST, Balter MB, et al: Popular attitudes & beliefs about tranquilizers. Am J Psy 130:1246, 1973.
5. Balter MB: An analysis of psychotherapeutic drug consumption in the United States. Proceedings of the Anglo-American Conference on Drug Abuse, I: Etiology of Drug Abuse, p 58, 1973.
6. Balter MB, Levine J, Manheimer DI, et al: Cross-national study of the extent of anti-anxiety/sedative drug use. NEJM 290:769, 1974.
7. Parry HJ, Balter MB, Mellinger GD, et al: National patterns of psychotherapeutic drug use. Arch Gen Psy 28:769-783, 1973.
8. Balter MB: Coping with illness: choices, alternatives and consequences, in Helms RB: Drug Development and Marketing. Washington, DC, American Enterprise Institute for Public Policy Research, pp 27-45, 1975.
9. Hollister L: Drugs for emotional disorders. JAMA 234:942, 1975.



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NAMING AND DEVELOPING AN OFFICE MANAGER

Part 2

LEIF C. BECK, LL.B., C.P.B.C.
VASILIOS J. KALOGREDIS, J.D.

In last month's article we expressed the challenge, and the risk, involved in designating and developing an office manager. Upgrading the so-called "super-aide" towards the role of full-time office manager may cause her to become lost as an effective employee if she fails to manage satisfactorily. The Peter Principle applies all too well.

The success or failure of the new manager probably depends more on the physician(s) in final charge than on the selected person. The physician(s) must be conscientious and perceptive in developing the office manager role, a task which can be challenging for a doctor since it is somewhat ego-threatening. He will be building up a subordinate to assume much of his own authority. If he keeps firmly in mind that the build-up allows him to extend himself, having responsibilities carried out for his benefit and subject to his overall satisfaction, he will hopefully undertake the challenge with real enthusiasm.

This month's article will thus consider the important aspects of developing a so-called "super-aide" into a more effective office manager.

Management Needs Time and Attention

A person simply cannot be expected to be an

Messrs. Beck and Kalogredis are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd, Pennsylvania.

effective manager if she must devote her full time and energy to regular office duties. She must therefore avoid the regular jobs as much as possible: sitting all day at the reception desk, handling all the insurance forms, and so on. The office manager develops routines and policies that cause the jobs to be well-handled; she does not simply do those jobs herself.

A promoted super-aide's instinct is so often to fill in on each crisis. She may have been selected because of that very instinct, as the most conscientious employee who would assume any burden when another employee fell behind or was absent. The change away from this instinct is never easy, but her success will come from developing patterns that cause the crises to be covered—not from running herself ragged covering them herself.

Management requires thinking time, so the business systems and people patterns can be evaluated and modified for long-term success. Even handling the staff calls for time in subtly communicating with them. To entrust a person with the "office manager" responsibility and then deprive her of the time to discharge it is unfair.

Perhaps two examples will help. In one practice survey, we encountered a full-time manager who had become so bogged down by the clerical demands of a one-year-old computer billing system that the office was in near chaos. Our ad-

vice was to delegate those demands, for they did not require her level of talents, and resume attention to the entire office's problems or be replaced.

In another case, a uniquely conscientious employee was spending upwards of 70 hours a week trying to handle regular bookkeeping chores, finish up all unprepared insurance forms, and generally run the office. The practice was, however, slipping for reasons attributable in part to its staff and systems. We urged hiring an additional employee to free up the manager for what she could do most to help that office.

Freeing a super-aide from her regular working duties must be accomplished delicately. Other assistants can become resentful over "one of their group" being exempted from the work. Especially since that manager may no longer have quantitative assignments (other than the vague term "to manage") and may then assign her previous work to others, the reaction is understandable. If the selected manager is perceptive and the doctor(s) back her up diplomatically, the problem can usually be overcome.

Management Needs the Doctor's Support

The selected office manager absolutely must have an agreed level of authority over the staff, and it must in no event be undercut. Any appearance that an employee can by-pass the manager can be fatal to her role. Each physician must keep this requirement firmly in mind and resolve to be consistent in his reliance on his manager.

A doctor may nevertheless receive requests and suggestions directly from his staff, for the manager cannot become a means of shutting off open discussion. He might acknowledge the requests and/or suggestions with his comment that he will discuss it with the manager for their joint decision. If he feels strongly enough, he might then even order his manager to handle the problem a certain way for he is in charge, but the image of managerial responsibility will be maintained. To decide the point promptly in the employee's presence, however, would destroy the manager's authority and possibly overlook factors not even presented to him upon the employee's one-sided request.

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The opposite side of this authority point is the need to develop an open, cooperative office. Therefore, communication at and between all levels should be encouraged. A manager who attempts to stifle the communication will soon lose her capability to motivate the staff. As a result, we sometimes lecture office managers to "keep it warm and open but fight like hell if you're undercut."

Management Needs Daily Time with an Owner

Even if for only ten minutes a day, the office manager must have a chance to communicate with the physician owner(s). She must have the guidance of her superiors like anyone else, and the doctor(s) have to stay tuned to her work. They must remember their undertaking to "manage the manager."

Some practices meet this need by scheduling the first fifteen minutes of each morning for manager-physician discussion. He can then give her any special instructions and raise his or his group's concerns. She can describe her progress

on any undertakings, raise problems and questions, and generally be sure her plans are understood and respected by the physician-owner(s). Forcing the daily interchange into the doctor's pattern can thus help assure effective management.

The required communication includes ongoing evaluation and criticism of the manager's performance. She requires such work review even more than the staff, but her higher position of responsibility too often deters the doctors from facing up to her good and bad points. We recently worked with a surgical practice which decided to terminate the manager's employment because of deficiencies which, we feel, could have been overcome if they had been candidly discussed over the several prior years. The manager's job is too essential to the doctors to proceed without such guidance.

Management Requires Being an "Insider"

We urge physicians to include their office managers in virtually all of their inter-doctor business meetings. The manager should be considered an "executive" both privileged and responsible to participate at the decision-making level.

At the meetings, her task should first be to report on the business. She should present and discuss its most recent financial report and her concerns or recommendations. She should also report on her progress as to matters previously decided upon, thus holding her responsible that progress is in fact being made.

Physicians' business meetings are notoriously unproductive, but intelligent use of the office manager can dramatically upgrade their effectiveness. The manager should see each doctor several days in advance to determine what items he wants discussed, upon which a meeting agenda can be made and distributed for thought before the meeting even begins. At the meetings, she should take notes and remind various doctors afterwards of things they had agreed to handle. In this respect, the manager can help the doctors become better "doers" themselves.

Perhaps even more importantly, the manager can assume responsibility to carry out decisions

made at the doctors' meetings. A decision is more likely to be implemented by a subordinate, whose job depends on doing so, than by one doctor among equals. And her doing so frees up doctor time for his other demands. The undertaking and its subtleties will be far better understood if the manager participated in the meeting than if she were afterwards given a bare instruction.

Some doctors consider their practice finances so confidential that even the office manager is not privy to them. We consider this attitude extremely unwise, for there is really nothing to gain from such confidentiality. Instead, the inclusion of a manager into the financial planning and monitoring makes her more of an "insider" able to apply the economics to office decisions.

The Position Needs Its Description

Fairness to the selected manager calls for defining her new responsibilities as clearly as possible. Thus a written job description should be developed and discussed candidly from the beginning. One practice's description was presented as "Exhibit A" of last month's article and may be useful.

There will still be a considerable lack of clarity as to all the manager's activities, but the exercise of quantifying them as much as possible must nevertheless occur. Then, as new responsibilities present themselves or as existing duties change, the writing should also be changed. While any employee's job definition should undergo constant reconsideration, the office manager's should probably be the most flexible of all.

Incidentally, one of a new manager's earliest tasks should be to review and possibly republish all employees' job descriptions. She may have some fresh ideas of how the various assistants can most effectively work, and her efforts in these regards should be encouraged. And the mere exercise of reviewing each person's duties, both individually and collectively for the entire staff, is an unusually fine educational experience—probably causing her to understand the office's interactions better than ever before.

Success May Come Slowly

The doctor(s) cannot simply assume that an

office will function smoothly shortly after a manager's selection. It will take time for her to settle into the job, for her desired improvements to be made, and even for the staff to accept her role at all. Patience will thus be required on both sides, with the physician(s) particularly being alert to help her develop until results are actually seen.

We have sometimes said that a manager will become more effective with later generations of employees. Those assistants already in their jobs when an office manager is thrust upon them may resist responding properly, but employees thereafter recruited and hired by the manager will much more likely accept her role. This can be another reason for being patient, but if one or more employees interfere with the new relationship, they may have to be replaced.

The doctor(s) should give their highest trust and support to their selected manager, even at the expense of other good employees, until and unless they conclude that the manager herself is failing. As we say, "The manager should be given enough rope to hang herself with," which is why the position is such a challenge and risk to both sides.

Conclusion

Designating someone as office manager is obviously only the beginning. The physician(s) must thereafter give their attention and support to helping her become effective, for her success will in large part depend on the doctors. A successful office manager should be a matter of great pride to the physician-owner(s), while she rewards the practice with the attention it deserves.

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Highlights



ESTROGEN THERAPY: CAPSULE COMMENTS

WILLIAM G. SLATE, M.B., ChB., M.S., *Director, Department of Obstetrics and Gynecology, Wilmington Medical Center, Wilmington, Delaware. Adapted from a presentation at Kent General Hospital February 28, 1978 in the Continuing Medical Education Seminars for Physicians.*

1. Estrogen therapy is valuable for women whose climacteric symptoms are specific for lack of estrogen. These include severe vasomotor symptoms (hot flashes or sweats), and atrophy of the genitourinary tract epithelium, causing dyspareunia and predisposing to recurrent vaginal infections and discharge. Estrogen deficiency may also contribute to dysuria and stress urinary incontinence.

2. Estrogen therapy is also used for the prevention of osteoporosis.

"Of the estimated 4.2 million women in the United States with severe osteoporosis, 700,000 per year will suffer fractures leading to disability, deterioration, and, in a substantial number, death."¹ Prevention of incapacitating osteoporosis requires only small doses of estrogen and should be accompanied by a regular exercise program, two to three glasses of milk per day, weight maintenance a little above optimum, and cessation of smoking.

3. Before estrogen is prescribed in the climacteric years, the endometrium should be sampled.

4. Regular medical surveillance of all patients receiving estrogens is essential, including pelvic examination and cytologic screening

at least on an annual basis. Periodic evaluations should be made of the need to continue estrogen therapy.

5. Continuous use of estrogens is likely to produce endometrial hyperplasia; therefore administration should be intermittent (cyclic). The lowest dose that will relieve symptoms should be prescribed for as short a time as possible.

6. Climacteric women who have an intact uterus and are receiving estrogens require breast and pelvic examination at six-month intervals. Annual cervical Papanicolaou smears and endometrial sampling should be done.

7. In women with previous cancer of the breast, estrogens should not be prescribed if the mammary carcinoma proved to be estrogen-receptor positive.²

8. An association, but not causation, had been demonstrated between exposure to exogenous estrogens and endometrial cancer.³

9. An association between estrogens, exogenous or endogenous, and the development of endometrial hyperplasia and carcinoma have been recognized for almost half a century.⁴

10. Estrogen users have an increased incidence of endometrial cancer (in the range of 7x that for non-users), but proof does not exist that estrogen alone is the carcinogen.⁵

REFERENCES

1. Follingstad AH: Estroil, the forgotten estrogen? *JAMA* 239: 29, 1978.
2. Jones Jr, HW: Editorial Comments. *Obst & Gynec Survey* 32: 619, 1977.
3. Hoogerland DL: University of Wisconsin. *OB-GYN News* 1: 14, 1978.
4. Kistner RW: Histologic effects of progestins on hyperplasia and carcinoma in situ of the endometrium. *Cancer* 12:1106, 1959.
5. Kistner RW: Treatment of premenopausal and postmenopausal women. *J Reprod Med* 19:103, 1977.

Letters to the Editor

To the Editor:

We recently read the review of our book in the March issue of the *Delaware Medical Journal*. It was encouraging to read that you liked our bibliographies and our positive suggestions and that you feel that our book will probably be used as a text by many types of health personnel. However, your comment about our material on the technical aspects of communication was not substantiated, your remark about our suggestion concerning children who use obscenities seemed flip and did not accurately represent our statements, your question about photo credits was an offensive way for you to identify a photographer, and you inaccurately reported the cost of our book as \$12.95 when the actual cost is \$5.95.

It would be helpful to us if you could explain why you were left "cold and unconvinced" by our discussion of the technical aspects of communication. Also, we suggest that you read page 88 in our book again and see exactly what we have said about children who use obscenities. In addition, if you had bothered to ask us directly and personally why Don Russell was not credited by name in our book you would have learned: (1) that in consultation with our editor we decided against using any personal acknowledgments (a privilege we have as authors) and (2) that the acknowledgment we used for the photographs was "cleared" through the Public Affairs Department at the Wilmington Medical Center. Finally if you paid \$12.95 for a paperbound copy of our book, you should write to Prentice-Hall and ask for a \$7.00 refund.

DENNIS R. KLINZING
DENE G. KLINZING

The Klinzings must be right about the price of their own book. My information about the photographer's name who did their great cover photo was wrong. Since she had left the Medical Center's employ by the time of publication, it was decided to credit her photo to the Center in general—not the best procedure, in my opinion, although apparently

legitimate. As for my remarks regarding my reaction to the Klinzings' text, cold reactions from readers are a hazard to all authors. I surmise the hazard may be especially so for soft scientists when their reading audience is other than their students or members of their own academic fraternity. It's an occupational risk for all authors, including book reviewers, to have their output less well received than they would like.

We wish them well with their book.

B.Z.P.

To the Editor:

In recent years, husbands on an international scale have been receiving preparation for childbirth training and accompanying their wives through labor and delivery.

Dr. Michael Goodman, a veteran of 600 such deliveries, reports that these fathers make up a wide spectrum of backgrounds and that "... almost without exception they had one thing in common: they were a great help to their women, were elated and elevated by the experience, and in the process, I think felt much closer to their newborn child . . ."¹ The birth of a child can be a very emotional and joyful experience for both parents. Many hospitals, including the Wilmington Medical Center, have come to recognize the importance of having the fathers present during labor and delivery through natural means. However, those husbands whose wives must have a cesarean operation are currently being deprived of the joys associated with participatory childbirth because of policies which prohibit access to operating rooms.

Should one take a very brief look at the development of modern thought on operating room privileges, one may see a reason why physicians might not want the father present during the cesarean operation. Since World War II the fear of cross-infection has suggested that as few people as possible be present during an opera-

tion;² only those actively contributing to the performance of the operation should be present. Because the father would be giving support to his wife during surgery, he could be looked upon as an integral part of the surgical team; however, the surgeon should have the authority to decide whether or not the father is capable of being or remaining present.

With the mounting pressure generated on the medical profession by numerous malpractice suits, one might expect some doctors to become overly concerned about what to do if an emergency occurred while the father is present. Biller and Meredith report that "... hospitals that allow husbands in delivery rooms find that fathers, in fact, gain a great deal of respect for doctors, by watching them handle emergencies."³ One might assume similar reactions for fathers in the operating room until experience shows differently.

We cesarean birth fathers ask that those of us who wish to share in the joy of childbirth with our wives be allowed to do so even when the childbirth is by cesarean section.

SHERMAN N. MILLER

REFERENCES

1. McCauley CS: Pregnancy after 35, p 172. New York, EP Dutton and Co, 1976
2. Cartwright FF: The Development of Modern Surgery, p 284. Thomas Y Cronwell Co, 1967.
3. Meredith D, Biller H: Father Power, p 44. New York, David McKay Co, Inc, 1974.

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To the Editor:

I would like to call everyone's attention to a recent article, "Good News about Senility," by Arthur S. Freese which appeared in the February-March 1978 issue of *Modern Maturity* and which quotes Dr. Robert N. Butler, Director of the National Institute of Aging; Dr. Leslie S. Libow, medical director of the Long Island Jewish Institute of Geriatric Care, and Dr. F. Marott Sinex, biochemist, and co-director of Boston University's Gerontology Clinic.

There experts consider the word senility a very confusing term with no real medical legitimacy. It is a lay term, which doesn't exist in medical literature. True senility is really a de-

mentia for which the correct name is Alzheimer's Disease.

Alzheimer was a German neurologist who first described dementia and who found that the disease is almost as likely to appear in middle-aged people as in older ones.

The cause of dementia is unknown. Etiological factors include anemia, dehydration, congestive heart failure, mild infections, heat, drugs, depression, and possibly other metabolic errors.

Senile dementia is not a natural phenomenon; it is not as inevitable as graying of the hair in the elderly.

Dr. Stephen H. Zarit, professor of psychology at USC's Andrus Gerontology Center in Los Angeles, finds that old age in healthy people does not affect memory to any significant degree.

Reversible senilities, which are called pseudo-senilities, look like senility but are treatable and reversible. In these drugs should be used with extraordinary care. Diagnosis should be early and treatment by mild medication and psychotherapy prompt.

Physicians especially and also others need to alter their use of the word "senility."

C. L. HUDIBURG, M.D.

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To the Editor:

From 1970 to 1972 the Ad Hoc Committee for Prepaid Care of the Medical Society of Delaware worked on a proposal for a cooperative plan with Blue Cross-Blue Shield of Delaware for prepaid care. This committee in 1972 evolved into the Delaware Foundation for Medical Care, which for the next two years tried unsuccessfully to launch its pilot project.

Now in 1978 the picture has changed. Across the country in the interim many medical societies have started similar prepaid plans which have proved to be successful. And here in Delaware the duPont Company has become interested in securing a prepaid care plan for its employees and their families to attempt to hold down spiralling costs and still keep up the quality of health care.

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In New Castle County alone the duPont Company employees plus family members number approximately 75,000. This is more than sufficient to support a closed panel plan; experience has shown that such a plan works for 30,000 or more enrollees. The plan could be staffed by presently salaried duPont Company physicians augmented by newly hired physicians as needed. Operation of such a plan would not involve community physicians and would surely interfere with present doctor-patient relationships.

But the duPont Company is concerned with the greater community health problems and is now studying the feasibility of an open panel plan, a so-called IPA, an Individual Practice Association. Under this plan any licensed physician in the state will have free choice of joining for one year, and of exercising once every year his option to continue to participate or to withdraw. Similarly every head of household will have free choice of joining the IPA for a year, or of securing either directly or through his employer enrollment in a Blue Cross-Blue Shield or private insurance company conventional plan; and this choice will be open to him to exercise once every year.

Under the open panel IPA plan, present patterns of practice will be maintained. Each participating physician will see prepaid care patients in his own office along with his usual patients. All enrolled patients will have free choice of participating physicians. If, as is hoped, the majority of physicians in the community elect to participate, there will be little change in doctor-patient relationships.

The duPont Company selected Employers Insurance of Wausau to conduct its present feasibility study because this insurance company has had experience in establishing a successful IPA in Wisconsin. So far the duPont Company has no commitment relative to who will operate the plan when developed.

Blue Cross-Blue Shield of Delaware had initiated its own feasibility study for a prepaid care plan sometime ago.

It would be tragic if our efforts are fragmented and we end up with two separate and competing plans, especially if the duPont Company plan is joined by some of our other large corporations to

siphon off the relatively healthy segment of the population. This would leave the Blue Cross-Blue Shield plan with the remaining higher risk patients and raise the premiums for health insurance sharply for those who need it most.

Blue Cross-Blue Shield of Delaware has had long experience with health care in this state and has learned to work well with subscribers, physicians, and hospitals. Approximately 80% of the insurables in Delaware have Blue Cross and/or Blue Shield coverage. The best interests of the community will be served if physicians will join with the duPont Company and Blue Cross-Blue Shield of Delaware as a team for a one-year trial of a comprehensive Individual Practice Association-type open panel Prepaid Health Care Plan.

DAVID PLATT, M.D.

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To the Editor:

I would like to call the attention of *Delaware Medical Journal* readers to the recently recognized probable hazard from ophthalmic 10% phenylephrine reported in a paper entitled "Possible Adverse Effects from Topical Ocular 10% Phenylephrine" in the April issue of the *American Journal of Ophthalmology*.

Although the report is preliminary, 33 instances of adverse side effects have been collected. Fifteen of these were myocardial infarcts, eleven of which were fatal. In seven additional patients, cardiopulmonary resuscitation was necessary. The remainder were primarily instances of marked increase in systemic blood pressure.

Because of this report, I feel the use of 10% ophthalmic phenylephrine should presently be limited to patients who require wide dilatation of the pupil and who have no history of previous cardiac disease of hypertension. Patients taking tricyclic antidepressants or monoamine oxidase inhibitors are probably also in a high risk category. The use of 2½% ophthalmic topical phenylephrine may be considered as a substitute; however, its safety has not been proven. At the present time, both drugs should be used with extreme caution.

ALVIN WEINER, M.D.

Book Reviews

FEMALE PSYCHOLOGY: CONTEMPORARY PSYCHOANALYTIC VIEWS edited by **Harold P. Blum, M.D.**, International Universities Press, Inc., New York, 1977. 454 pp. Price \$22.50.

Female Psychology is a collection of 17 psychoanalytic articles covering such a diverse range of topics as regression and reintegration in pregnancy, work inhibitions in women, sleep orgasm, and the ever popular penis envy.

Most of the articles conform to the same format: they begin with a brief theoretical statement and spend the majority of the paper presenting illustrative case histories. The papers are organized in a developmental sequence, with issues of infancy coming first, followed by the oedipus complex, penis envy, and finally issues on adult feminine development.

Unfortunately, this is not a book that would help the practicing analyst. The actual work of therapy is not described in enough detail to understand the techniques being used and the theories are too sketchy to allow analysis of one's own clients.

Another drawback is that many of the articles laboriously spend time rejecting analytic premises that it is doubtful anyone but the originator of the idea believed.

For instance, Kleeman, writing on Freud's early views, tries to debunk the idea that reddening of the genitals is irretrievably and always the result of a female child stimulating or masturbating herself. Kleeman's observations were that genital redness encouraged scratching or other forms of stimulation. Thus, he concludes that the skin rash is usually primary, and self-stimulation follows. A red hot observation.

Not all the articles are this ridiculous. Jane Kestenberg, for instance, attempted to do a research project analyzing the changing dynamics of women during pregnancy and used Anna Freud's metapsychological assessment categories. Apparently oblivious to the problem of experimenter bias, Kestenberg is the only rater of the

material. Yet, her conclusions are an interesting variation of the fascinating concept of gestation recapitulating ontogeny. She found that during the first trimester, oral incorporative trends reflect the attachment of the fetus to the mother; the second trimester, characterized by a securely attached fetus, is associated with retentive trends that aid in the recognition of the fetus as a separate object; and finally in the third trimester, urethral letting-go trends act as an aid for the anticipated conversion of the internal into an external object.

Overall, despite a few moments of cogent thought and clever writing, I thought this a dull, outdated, and dimwitted collection. Other books in the field are better.

LINDA BERG-CROSS, Ph.D.

Dr. Berg-Cross is Associate Professor of Psychology at the University of Delaware.



HOME MEDICINE by **John E. Hocutt, Jr., M.D.**, Nottingham Corporation, Inc., Newark, Delaware, 1976. 52 pp. Spiral-bound. Price \$3.95.

John E. Hocutt, Jr., M.D., (a family practice resident at the Wilmington Medical Center), has prepared a valuable publication in the field of home medicine. This paperbound volume was published in 1976 but only recently given to this reviewer for evaluation. It seems unfair for such a volume (prepared for laypeople) to be exposed only to the bias of a physician reviewer. Therefore, this review appears jointly with the opinion of a layperson who has had no medical training but is the mother of a sixteen-month old charmer.

The author includes most of the medical problems of concern to the average family, discussing each in simple and practical terms. The advice is sound with appropriate concern for consulting a physician if and when the problem progresses.

Particularly interesting is the listing of medical myths, a section not included in most manuals of home medicine. Has the author helped propo-

gate medical myths by suggesting that fruit juices are valuable in the treatment of colds and that the fungi of epidermophytosis are recurrently acquired from an exogenous source?

Dr. Hocutt deserves credit for downgrading the importance of milk in the diet of older children and adults; the American male in particular cannot receive that message too often.

Physicians may heartily endorse this publication for use by families in their practice.

WILLIAM J. HOLLOWAY, M.D.

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HOME MEDICINE by John E. Hocutt, Jr., M.D., Nottingham Corporation, Inc., Newark, Delaware, 1976. 52 pp. Spiral-bound. Price \$3.95.

In *Home Medicine*, Dr. John E. Hocutt has given the layperson a valuable guide for home health care with a somewhat different approach. Common health problems are discussed (ie, colds, diarrhea, burns, etc.), but Dr. Hocutt goes

a step further by including sections on such matters of public interest as weight loss, vitamins, sleep, Medic Alert, medical myths, and safety in the first year of life. It is relatively easy to find an adequate home guide for medical problems and emergencies, and it is refreshing to come across a guide which stresses total physical well-being.

My chief complaint with *Home Medicine* is that it does not go far enough in its discussion of many of the topics. In reading the book, a number of obvious questions come to mind which Dr. Hocutt could have answered with a minimum of verbosity. For example, what is tetanus? What causes hiccups? What foods are good sources of the vitamins under discussion? While recognizing that *Home Medicine* aims for a brief discussion of health guidelines, I feel that the author could have more fully informed his readers on some of the topics without sacrificing brevity or conciseness.

Another criticism of *Home Medicine* is that, while purporting to address itself to the average

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medical consumer, it uses a number of terms (which are not explained in the glossary) with which the target reader is unfamiliar. I would venture to guess that terms such as "static water," "distal rectum," "friable," and "cathartic" are not included in the average layperson's vocabulary. In addition, improvement could be made on some of the organizational aspects of the book. By way of illustration, if my child had just swallowed a handful of mothballs and I was frantically searching for the section on poisons, it would never occur to me to look first under "A" for "Accidental Home Poisoning."

Despite these shortcomings, *Home Medicine* basically accomplishes what it sets out to do, that is, to "assist you in improving your medical care and, at the same time, to decrease the annual cost of such care." It would be a worthwhile addition to any family's home library.

BARBARA HOLLOWAY



ADVANCES IN SURGERY, Vol. 11, edited by Charles Rob, Year Book Medical Publishers, Chicago, 1977. 415 pp. Price \$28.50.

This fine volume, written by experts, is primarily intended for surgeons, residents, and ancillary specialists engaged in the care of surgical patients. Hyperalimentation and microsurgery, which have almost become subspecialties, are subjects which are aptly handled. Abdominal ultrasound, now occupying an important place in the rapid and noninvasive investigation of abdominal masses, is well discussed. The problems of colitis, both ulcerative and granulomatous, and acute respiratory distress have been updated. The role of adjuvant chemotherapy has been well defined. The review of the postoperative drug therapy and the handling of the critically ill surgical patient are well presented. Other chapters intensively review arterial embolism and hand injuries.

On the whole, this is a useful book to catch up with many of the recent rapid developments in surgery.

SHIVDEV SINGH, M.D.



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HANDBOOK OF NONPRESCRIPTION DRUGS, 5th Ed., edited by Cynthia Kleinfeld, American Pharmaceutical Association, Washington, D.C., 1977. 388 pp. Illus.

Written primarily for pharmacists, this book is a valuable reference for the physician in primary care.

Thirty-two sections cover different classifications of nonprescription medications. Each includes a discussion of related anatomy, physiology, and pharmacology along with their recommended advice to be given by the pharmacist to the patients. Finally, each section is concluded with a comprehensive list of all (dare I say all?) over-the-counter medications in the chosen classification with their components listed by dose.

The component drug lists should be helpful to all primary care physicians at one time or another. The somewhat simplified discussions in each chapter will not replace Goodman and Gillman, but it is a reference far superior to a PDR-type review. The narration could also serve as a vehicle for patient education for the industrious physician.

The discussions are enlightening and do make interesting reading. For example, mouthwashes compared to toothpastes are really put down. Fever blisters are contrasted to canker sores, and the distinction emerges amazingly clear. Did you know there are 211 over-the-counter multivitamin preparations? And you should see the interesting and sound advice a pharmacist is encouraged to give the patient.

JOHN E. HOCUTT, JR., M.D.

NURSING MANAGEMENT OF DIABETES MELLITUS edited by Diana W. Guthrie and Richard Guthrie, The C. V. Mosby Company, St. Louis, 1977. 283 pp. Illus. Price \$8.95. Paperback.

Only the lightly trained have the temerity to abstract huge gobs of medicine into several didactic and easy-to-read pages. The genetics section is incorrect, but this is still a useful book for those who teach diabetic patients—which means all those who care for them.

PATIENT COMPLIANCE edited by Louis Lasagna, M.D., Futura Publishing Company, Mount Kisco, New York, 1976. 162 pp. Illus. Price \$14.50.

ADHERING TO MEDICAL REGIMENS: PILOT EXPERIMENTS IN PATIENT EDUCATION AND SOCIAL SUPPORT by Robert D. Caplan, Elizabeth A. R. Robinson, John R. P. French, Jr., John R. Caldwell, and Marybeth Shinn, The University of Michigan Institute for Social Research, Ann Arbor, Michigan, 1976. 284 pp. Price \$10.00.

The first book consists of papers presented at a meeting entitled Principles and Techniques of Human Research and Therapeutics. The presentation includes a foreword by Senator Kennedy as well as some radical nurse-talk. The collection is an interesting revelation of just how complicated a scientific understanding of something as seemingly simple as patient compliance in recommended regimens can be.

The second book on the same subject is more difficult to read since it contains sentences like these: "Social support may buffer the effects of demands of the regimen on strain. Consequently



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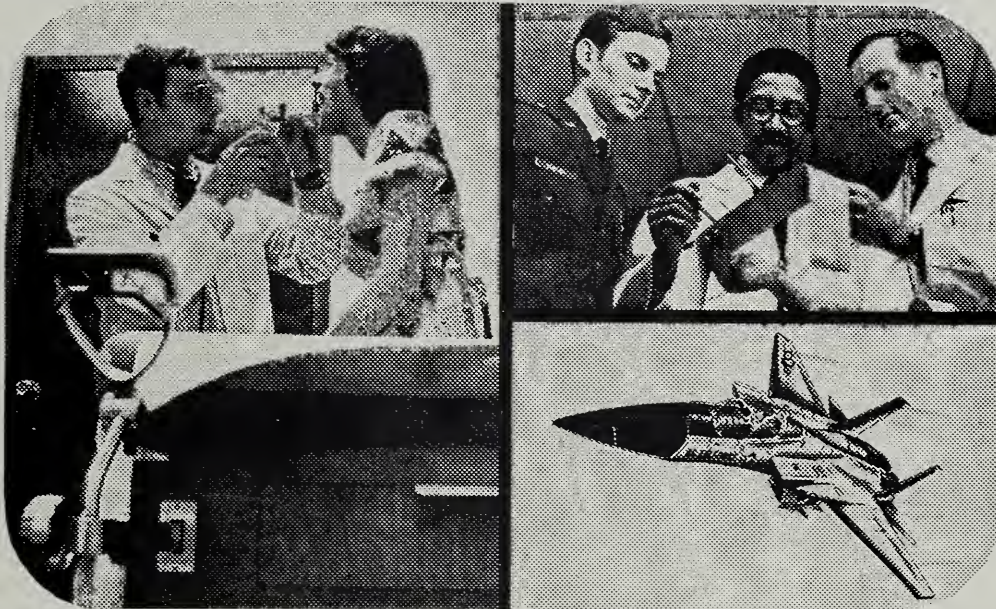
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demands may be associated with strain only for persons low in social support. If, however, support has the effect of threatening peoples' sense of autonomy and independence, buffering may not occur."

Compliance is a hot issue just now. Any doctor could spend a useful evening browsing these books.

THE CHANGING HEALTH CARE TEAM IMPROVING EFFECTIVENESS IN PATIENT CARE edited by Spring Zoog, and Stephen Yarnall, M.D., MCSA, Seattle, 1976. 179 pp. Illus. Price \$17.50.

This is a collation of the papers delivered at a conference of the same name in Hawaii a year or two ago, all still current, and often controversial. At the close of his discussion of strategies for changes, Yarnall quotes (a bit irrelevantly, but then how many American physicians could do it?) a Swahili proverb: "Bandu, bandu, humala gogo," which translates to "Chip, chip,

the block finishes." Recommended to those who like to keep abreast of changing currents in medical care delivery such as "Patient counseling by Computer" and "A Health Care System Designed to Give Rewards for the Maintenance of Health Rather Than Just for the Treatment of Illness."

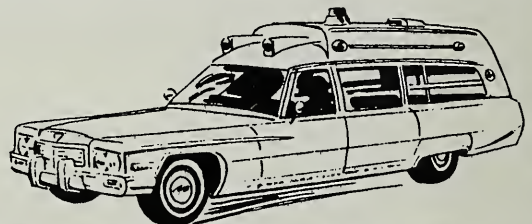
THE GENETIC APPROACH TO HUMAN DISEASE by Vincent M. Riccardi, M.D., Oxford University Press, New York, 1977. 273 pp. Price \$13.95.

This book was written because the author was so frequently asked to suggest a book giving an overview of clinical genetics and had none to recommend.

"One of the chief purposes of medical genetics is to give information to couples on risks of disease in future children, and to put the risk in perspective for them both in the relation to random risks and the prognosis of the child, if affected," says the foreword.

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The science has certainly come a long way since Mendel's peas. This a good book for people who need to know the meaning of words like allele, compound heterozygote, and what is a wild-type. (A wild-type is "the nonmutated allele at a gene locus; usually the commonest allele.") This term can be helpful since it implies that a mutant gene is not automatically considered to be pathologic, ie, not normal, rather merely distinct from the wild-type."

Is that perfectly clear? A very useful book.

BERNADINE Z. PAULSHOCK, M.D.

ESSENTIALS OF ECHOCARDIOGRAPHY by **Benedict A. Termini, M.D.** and **Yu-Chen Lee, M.D.**, Medical Economics Company, Oradell, New Jersey, 1976. 104 pp. Illus. Price \$14.95.

This book is, according to the authors, "a short, non-technical, illustrated guide, outlining the indications for echocardiography and explaining the significance of major echocardiographic abnormalities."

It summarizes well the major indications for echocardiography and those abnormalities of the heart best diagnosed with ultrasound. The pictorial reproductions of the echocardiograms are of high quality. This book contains an abundance of echocardiograms but a scarcity of words. The writing is succinct and to the point; however, this book displays no major omissions and is up-to-date.

This book is best compared to *Electrocardiograms* by Dubin, ie, a short, easy-to-read volume that rapidly teaches the student and non-cardiologist how to read and interpret echocardiograms. My only criticism is that the book is slightly oversimplified.

I recommend this little volume to all medical libraries. Because of the reasonable cost and high quality many internists may desire to obtain this book for their own library.

HOWARD LEIBOWITZ, M.D.

THE MENTAL STATUS EXAMINATION IN NEUROLOGY by **Richard L. Strub, M.D.** and **F. William Black, Ph.D.**, F.A. Davis Company Publishers, Philadelphia, 1977. 176 pp. Illus. Price \$7.95. Paperback.

In a concise, easily readable, and organized way, Drs. Strub and Black have presented a useful guide to the evaluation of the mental status in patients presenting with neurologic, medical, and psychiatric disease. In addition to their step-by-step approach to aphasia, apraxia, memory deficits, orientation problems, etc, they stress the importance of detailed bedside testing by pointing out the anatomic areas responsible for each deficit.

Despite the gains in technology (eg, CAT scanning), there still is no substitute for accurate medical examination. To label a patient with a right parietal lobe sensory deficit "hysterical" is inexcusable when the diagnosis is easily made at bedside.

Hopefully, the guidelines herein described



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Book Reviews

will help to eliminate such errors. Although superficial at times and aimed primarily at the medical student, resident, and generalist, the volume is well done and useful to the neurologist and neurosurgeon as a quick review.

LANNY EDELSON, M.D.

❖ ❖ ❖

CURRENT DIAGNOSIS 5 edited by Howard F. Conn, M.D. and Rex B. Conn, M.D., W. B. Saunders Company, Philadelphia, 1977. 1272 pp. Illus. Price \$34.00.

This book is oriented towards the primary care physician. It contains a wealth of information and analyzes and lists the most common disease entities including history, physical examination, pertinent laboratory data, differential diagnosis, work-up, and treatment.

There are chapters on many of the usual disease entities as well as several short sections on obstetrics and gynecology and pediatrics. The latest diagnostic procedures are included. The editors state that the book is extensively re-writ-

ten quite frequently. As expected, there are a minimum of physiology and a maximum of clinical information.

This is a useful reference book for primary care physicians as well as all internists with a minimum of time for reading and the lack of desire to refer to the more sophisticated textbooks like Harrison.

This book is multi-authored, and some chapters go into more detail than others. By and large, the chapters are very well written. There are chapters on several important but uncommon diseases as well as those more usually seen.

HOWARD LEIBOWITZ, M.D.

❖ ❖ ❖

CHANGING SEXUAL VALUES AND THE FAMILY edited by G. Piroz Sholevar, M.D., Charles C. Thomas, Publisher, Springfield, Illinois, 1976. 192 pp. Price \$11.75.

What roles does a mother play in an incestuous sexual relationship between her husband and

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daughter? Can open discussion of virginity and pre-marital sex greatly affect a family's interrelationships? This monograph by the Family Institute of Philadelphia is an excellent addendum to discussions of the "generation gap" and "future shock," for it talks of the stresses that the family and individuals in the family experience as a result of society's changing moral and sexual values. These issues are reviewed in a series of essays by psychiatrists, psychologists, anthropologists and in discussions by two panels of college students.

In "Family System and Society," anthropologist Margaret Mead describes how the nuclear family has become an unnatural and isolated institution. By moving to a single home in the suburbs, today's family loses the advice and help of the extended family, and the support of a close-knit community. Accordingly, the family develops with a decreased sense of security and lacking in a variety of role models for its children. "I believe we have to recognize that what families need are other families . . .," she says.

Samuel Granick describes specific changes in society's sexual values: more open discussion of sexual topics in the media and within the family, an increasingly tolerant attitude towards pre-marital sex, and wider acceptance of pornography for sensual pleasure. How might these value changes affect the family? Granick feels that sex is an area where "conspiracies of silence" often occur that may create tensions and freeze communication and discussion in other areas. Optimistically, he sees that with the breaking of society's sexual taboos, family members are able to communicate more honestly and directly about

sex, thereby developing a deeper sense of trust, which makes family living a more cooperative process as parents and children share values openly.

The family therapist requires exquisite expertise to detect the subtle, emotion-laden games of family conflict. In a colorful and provocative essay, Dr. Carl Whittaker describes how he communicates to families with "loving-heartedness:"

"You can . . . talk directly to the parents when you are just talking to the kid. You say to a nine-year-old, 'Listen, did you ever think that the reason your mom is mad when dad comes home two hours late is because she thinks he is playing with his secretary after hours?' . . . And you have, by indirection, left a pill in mother's and father's teeth that they cannot deny and that they cannot possibly not have heard, and all sorts of funny things happen in the next two interviews, including the possibility they will not show up."

Whittaker further states that as the family therapist "if you can screw it up so that they cannot enjoy the way it is going anymore, they will work out ways of . . . living which will give them more enjoyment."

Changing Sexual Values and the Family is an enlightening book which the physician can read as a professional concerned about his patients and as a family member concerned about the family of which he is a part.

BRUCE A. GOLDBERG
Third-year medical student
Jefferson Medical College

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In Brief

Speakers on "Ask the Doctor"

Speakers for June 1978 on the Tuesday radio program (11:05 a.m., WDEL) produced by the Medical Society of Delaware are: June 6, *Anthony L. Cucuzella, M.D.*, Your Body—Abuse It; You'll Lose It; June 13, *James R. Dearworth, M.D.*, Marijuana; June 20, *Stephen H. Franklin, M.D.*, Cataracts; June 27, *R. Walter Powell, M.D.*, Obesity and Diabetes.

In the News

Wilmington physicians, *Pierre L. LeRoy, M.D.* and *Allen C. Wooden, M.D.*, with co-authors W. M. Bruner, Ph.D. and J. Goloskov, R.N., presented a paper "Historical Review of Methods and Devices for Determining and Treating Abnormal States of Intracranial Pressure" at the 13th Annual Meeting of the Association for the Advancement of Medical Instrumentation held in Washington, D.C. this spring.

James K. Bouzoukis, M.D., Director of Emergency Services, St. Francis Hospital, has been elected President of the Blood Bank of Delaware. Doctor Bouzoukis is the first medical doctor to serve as Board President since the Blood Bank began operations in 1955.

W. L. MacKenzie King, M.D. has been elected President of the Delaware Psychiatric Society. Other officers include *Aydin Z. Bill, M.D.*, Secretary-Treasurer; *Nicholas Bash, M.D.* and *Jerome Kay, M.D.*, Council Members.

Emergency Medicine

The Office of Emergency Medical Services, Emergency Department Nurses Association, and the County EMS Councils will sponsor the FIRST ANNUAL EMERGENCY MEDICAL SERVICES SEMINAR, June 10, 9 a.m. - 5 p.m. at the Georgetown Fire House, South Bedford Street, Georgetown. There will be

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a choice of five workshops, panel discussions, and exhibits. Registration deadline is June 1. The registration fee of \$3.00 covers lunch. For more information contact: Office of Emergency Medical Services, Division of Public Health, Jesse S. Cooper Building, Dover, Delaware 19901. Telephone: (302) 678-4710.

**National
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The American Heart Association will present the NATIONAL RESEARCH AWARDS 1979-1980 for support in the cardiovascular field including stroke and for related problems in the basic sciences. Awards will be given in Established Investigatorships and British-American Research Fellowships; application deadline is July 1. Applications for grants-in-aid are due by October 1. A doctoral degree is required for all categories. For information and application forms contact: Director of Research, American Heart Association, 7320 Greenville Avenue, Dallas, Texas 75231.

CLINICAL NOTICES AND MEETINGS

ACP Courses

The American College of Physicians will sponsor the following courses which may be used to fulfill Category I requirements for the AMA Physicians Award. For information contact: Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, PA 19104.

TOPICS IN CLINICAL HEMATOLOGY V: DISORDERS OF PROLIFERATION AND MATURATION, Waterville, Maine, July 10-12.

TOPICS IN CLINICAL ONCOLOGY V: MULTIDISCIPLINARY APPROACHES TO DIFFICULT CANCER PROBLEMS, Waterville, Maine, July 13-15.

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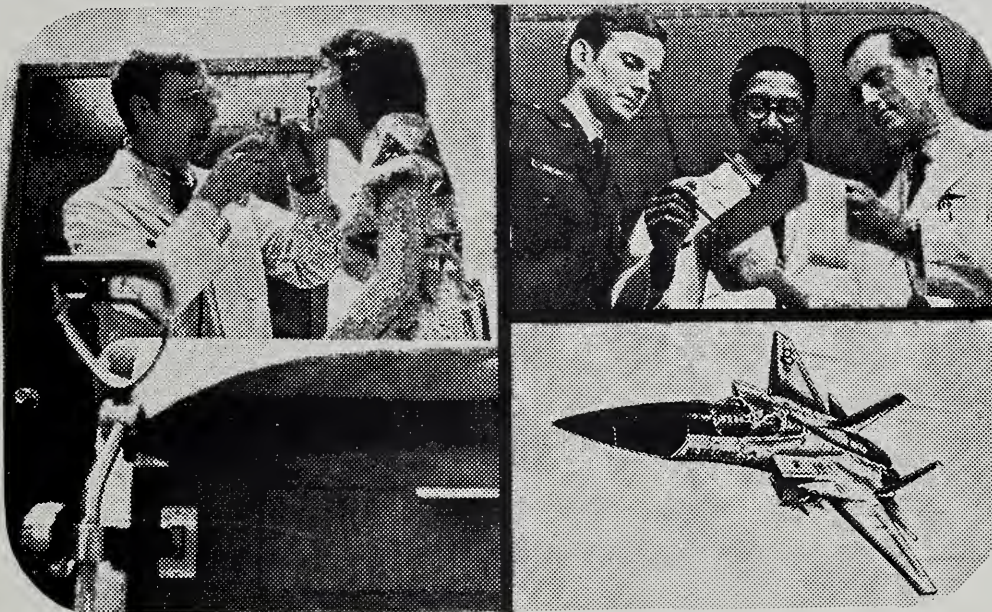
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cancer communiqué

FROM THE DELAWARE CANCER NETWORK*

NATIONAL CONFERENCE ON BREAST CANCER

RUBEN A. TELXIDO, M.D.

This is a report of the 17th Annual Conference on Detection and Treatment of the National Conference on Breast Cancer, which included the 6th Annual Wendell G. Scott Memorial Lecture, conducted in San Francisco, California, from March 6-9, 1978.

On the first day, in the morning session, Dr. Loren J. Humphrey spoke on immunization and breast cancer, stating that estrogen may enhance ductal hyperplasia in patients with fibrocystic disease; therefore, he recommended that patients with this disease be advised not to take contraceptives. The Diagnostic Panel, occupying the second portion of the morning, made the statement that the Memorial Sloan-Kettering Cancer Center was again examining fluid aspirated from breast cysts. Some institutions are practicing aspiration biopsies (smears) of solid tumors, and needle biopsy of solid tumors is becoming more frequently used. It is well understood that with the above-mentioned technique, negative reports are not definitive and therefore an open biopsy should follow.

In his paper, Dr. William Pomerance pleaded for time and deliberation before thermography is abandoned as a screening tool, stating that thermography has still to realize its potential.

The prime indications for mammography at this time were given as: surveillance of post mastectomy patients, family history of breast

cancer, and suspicious breast masses. Again, a plea was made that the benefits of mammography be carefully weighed against the potential harm so that we do not lose the position attained in the past ten years through judicious use of mammography.

Different techniques and refinements on the technique of mammography were presented with the photon technique on mylar introduced by Xonics promising good quality images with exposures of around 100 millirads.

Dr. Lundgren, representing breast projects in Sweden, spoke of one exposure (oblique medio-lateral view) as a good screening mammogram, and this view was supported by Dr. Philip Strax. Dr. Huffman, representing similar projects in Germany, disagreed on the basis that in his experience a large percentage of medial lesions are missed.

In hormonal manipulation of patients with breast tumors, it seems that estrogen antagonists are seeing more general use. The Adjuvant Chemotherapy Panel reported that a trend is under scrutiny regarding differences in responses between estrogen receptor positive and estrogen receptor negative patients.

The Pathology Panel presented a list of prognostic indicators in breast cancer:

- (1) Infiltration of par ductal lymphatic has a bad prognosis—almost equal to positive axillary nodes.

Dr. Telxido is Associate Director of the Delaware Cancer Network.

*An NCI-supported agency located at 1200 Jefferson Street, Wilmington, Delaware 19801. Tel. (302) 428-2113.

- (2) Nodal micro metastases measuring under two millimeters in diameter have a good prognosis.
- (3) Extension of tumor beyond capsule of lymph nodes has a bad prognosis.
- (4) Blood vessel invasion (this requiring stain for elastic tissue) has a very bad prognosis and is associated with early systemic dissemination.

One of the highlights of this conference was the Wendell G. Scott Memorial lecture, presented this year by Dr. Arthur I. Holleb of the American Cancer Society. He spoke of the quest for early breast cancer and described the development of breast demonstration projects in this country. The lecture described in detail the difficulties and controversy surrounding mammography and questioned the sensational publicity given to the findings of the Pathology Review Panel of the National Cancer Institute.

I am glad to report that Dr. Holleb's speech is scheduled for early publication in *Cancer*, and I would suggest that it would make very useful reading for all those who have been associated with the diagnosis and treatment of breast cancer.

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President's Page

WE HAVE A CHOICE

In the June issue of *Forum on Medicine** there is a provocative discussion on the effect of modern day practices to "corrupt" the American physician by shifting a large part of his individual responsibilities to third parties.

The article points out that from antiquity, the practice of medicine has been considered a profession whose practitioners are accorded special status only because they have an obligation to those who employ their services that is not shared by most persons in society. The complexity of the healing arts is so great that the "caveat emptor" rule governing ordinary purchases simply cannot apply. There has been a sacred quality of the physician-patient relationship recognized by both the profession and society. Basic to this relationship has been the physician's responsibility to the total patient. In his caring for each individual patient, the physician must consider the physical health, psychological well-being, and economic stability of the person being treated.

This triad of physician responsibility is solidly based. When any one of these factors is compromised, the relationship becomes unstable. Evidence is all around us that both the public and the profession perceive that the physician-patient relationship is deteriorating.

The author develops the thesis that the opening wedge in the weakening of the relationship is insurance of the physician's fee. This diffuses economic responsibility throughout society, so that neither physician nor patient is accountable. The ensuing

corruption reduces the physician to a mere technician.

The furor over "informed consent" arises when, in the absence of economic constraints, the patient is simply told what to do. The "right" to medical care is shown to make the patient less critical prospectively, but more critical retrospectively. The outburst of malpractice suits is a natural consequence. In short, the article illustrates that virtually every public issue impinging on the profession and the physician-patient relationship can be traced back to "physician insurance."

The writer, J. Lloyd Johnson, closes with a question and offers his personal answer:

"Are we as a society better off if, as our leaders in Washington advocate, we make medical diagnosis and treatment a right for all, or if we return it to the status of a privilege? Neither solution will be perfect. However, I would prefer to pick my own physician, have him treat me in my community hospital, and pay for the services with my after-tax dollars than to be at the mercy of employees of the same folks who brought me Amtrak, Vietnam, and the Postal Service."¹

Do we have the courage to refuse payment from anyone but the patient?



**Forum on Medicine* is published monthly by the American College of Physicians.

1. Johnson JL: Corrupting the American Physician. *Forum on medicine*. Vol 1, No 3: 13, 1978.



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SCAR CARCINOMA OF THE LUNG

DAVID V. PECORA, M.D.
STANTON F. CARROLL, M.D.
ROMAN KIS, M.D.
STEPHEN M. HANSON, M.D.

The relationship of chronic irritation, inflammation, and damage as forerunners of several types of malignancy has been established. Atypical epithelial proliferation can precede carcinoma in Bowen's disease of the skin and carcinoma of the uterine cervix.

For a long time, carcinoma of the lung has been associated with fibrosis due to many causes including tuberculosis, healed infarcts, pneumonia, and industrial irritants.¹⁻³ Some investigators have considered these carcinomas as separate forms of malignancy. It is our purpose to suggest that scarring of many origins may be a more frequent antecedent to cancer than generally realized.

CASE REPORTS

Case 1

W.C., a 49-year-old Caucasian male, was admitted with complaint of left shoulder pain. He was known to have Von Recklinghausen's neurofibromatosis since childhood. He smoked 20 cigarettes a day and consumed a large quantity of alcohol. Chest x-ray revealed a posterior-superior mediastinal mass. Pulmonary function studies suggested mild obstructive disease. Microscopic examination of material obtained by biopsy of the pulmonary mass via exploratory thoracotomy revealed scar tissue infiltrated extensively by pleomorphic carcinoma with numerous multinucleated giant cells. The scar appeared to the

pathologist to have arisen from preexisting inflammation. The carcinoma was arranged in solid cords and had extended to invade neighboring pleura, intercostal structures, rib, and vertebra.

Case 2

T.G., a 68-year-old male, who smoked ten cigarettes a day, was admitted for evaluation of occlusive arterial disease of the lower extremities. Routine chest roentgenogram revealed a coin lesion in the left lower lung field. Pulmonary function tests suggested a mild obstructive pattern. At surgical exploration, a 2.5 x 2 cm firm mass was removed from the superior segment of the left lower lobe. Microscopic examination revealed carcinoma in an apparent preexisting scar. Although the neoplasm appeared to include areas of adenocarcinoma, there were also foci of squamous metaplasia in an area of fibrosis which contained cholesterol clefts and anthracotic pigment.

Case 3

D.McL., a 63-year-old Caucasian male, who had smoked ten cigarettes a day for over 50 years and admitted consuming large quantities of alcohol, was admitted with the complaint of nonproductive cough of several weeks' duration. He had had tuberculosis 42 years previously and in the past had been treated for alcoholic myocardiopathy. Chest roentgenogram revealed densities in the right upper lung field and hilar area. Pulmonary function studies suggested moderate obstructive lung disease. Exploratory thoracotomy revealed an old Ghon complex. (Figures 1-4) Biopsy showed scar tissue containing entrapped anthracotic pigment and a well differentiated adenocarcinoma.

Case 4

J.C., a 60-year-old Caucasian male, who had smoked 20 cigarettes a day for 40 years and admitted a moderate alcohol intake, was admitted with complaint of pain in the left shoulder of one year's duration. Chest roentgenogram revealed a left apical lesion

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FIGURE 1

Center of ossified scar (Ghon complex) showing scar carcinoma in intraosseous spaces.

involving the second rib. Left upper lobe and partial chest wall resection were performed. Microscopic examination revealed poorly differentiated adenocarcinoma in an old scar. The bronchiolar epithelium in the area showed various degrees of hyperplasia. The scar included a considerable amount of anthracotic pigment.

Case 5

J.B., a 43-year-old Caucasian male, who smoked seven cigarettes a day and consumed alcohol occasionally, was admitted for urologic complaints. Routine chest roentgenogram revealed a coin lesion of the left upper lung field. The lung lesion was excised. Microscopic examination revealed a well differentiated adenocarcinoma occurring in scar tissue



FIGURE 2

Detail of Figure 1 showing malignant epithelial cells surrounding a spicule of bone.

of unknown etiology. Similar carcinoma was found in regional lymph nodes.

Case 6

J.S.P., a 58-year-old Caucasian male, had been treated for tuberculosis of the right upper lobe. Shortly before this admission, he developed an infiltrate in the left upper lung field. The lesion gradually increased in size. Cytological, mycobacterial, and fungal studies were not diagnostic. At exploratory thoracotomy, the left upper lobe lesion proved to be adenocarcinoma arising in scar tissue. Subsequent removal of the right upper lobe lesion also revealed adenocarcinoma, identical to the lesion removed from the left side. Excised lymph nodes contained metastatic adenocarcinoma.

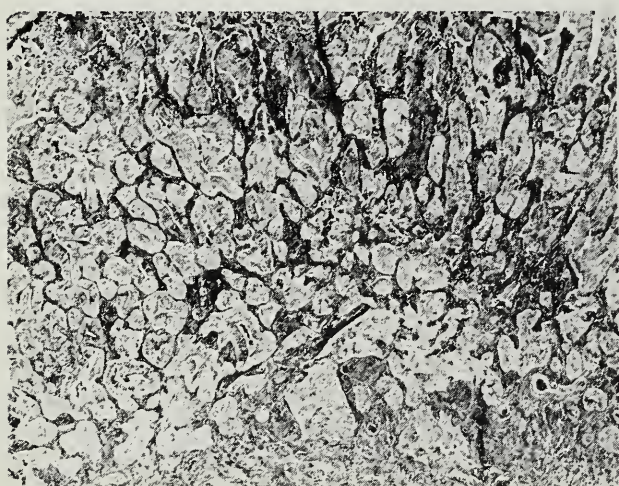


FIGURE 3

Low magnification view of periphery of the same ossified area showing florid fields of moderately differentiated adenocarcinoma.

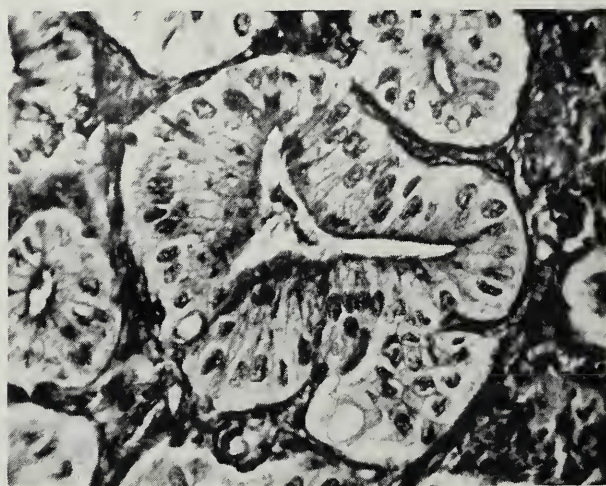


FIGURE 4

Detail of Figure 3 showing clusters of malignant glands.

Discussion

In each of our patients it is thought that scarring preceded neoplasia. Preexisting scar was distinguishable from desmoplasia secondary to carcinoma as scar existed in some areas without carcinoma; in other areas, carcinoma existed without scar.

Bronchioles and adjacent alveoli often respond to injury and inflammation by desquamation of epithelial cells. Injured bronchioles appear to respond as do bile ducts of the liver with proliferation and regeneration.⁴ Subsequently, bronchiolar epithelium may line injured alveolar walls as a single layer of cuboidal epithelium. Severe damage may cause bronchiolar epithelium to undergo squamous metaplasia. Often, epithelial cells continue to proliferate, filling the bronchiolar lumen with solid cords of cells. They may also enter adjacent alveoli. These solid aggregations of cells have been called "tumorlets," implying that they are premalignant.²

Fibrosis of the lung may follow either productive or destructive lesions and assume the form of a focal scar or more diffuse "honey combing" of chronic interstitial fibrosis.² Microscopic studies reveal that pulmonary fibrosis is frequently the cause of lymphatic obstruction as evidenced by the accumulation of anthracotic pigment. This might tend to concentrate carcinogens in the affected areas.⁴ Cholesterol, often found in scars, may also act as a carcinogen.² Although most lung cancers were originally assumed to have originated in the main bronchi or principal branches, accumulated evidence indicates that approximately half originate peripherally.^{5,6} Our experience and that of others indicates that there may be an increasing incidence of peripheral

carcinoma originating in scar of fibrotic areas. Meyer and Liebow found chronic interstitial fibrosis and atypical alveolar proliferation in 22 percent of 153 lung carcinomas.²

Histologically scar carcinoma may be either adeno- oat cell, or squamous carcinoma. Carroll reported 67% of adenocarcinomas are associated with scars.⁴ We have observed the same associations in approximately half of the peripheral adenocarcinomas we see. This statistical trend is likely to continue as more pathologists become aware of and look for the relationship of fibrosis and carcinoma.

Unfortunately, there is no simple method of diagnosing scar carcinomas. Indeed, since they occur in preexisting lung lesions, they may be overlooked. Since exploratory thoracotomy can usually be done with minimal risk, open biopsy should be employed whenever there is doubt regarding diagnosis and the patient's condition permits.

Summary

We are encountering an increasing incidence of pulmonary carcinoma associated with scarring. It is our impression after reviewing the literature and our own experience that many types of carcinoma may have in common preexisting injury and fibrosis.

REFERENCES

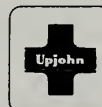
1. White FC, Beck F, Pecora DV: Coexisting primary lung carcinoma and pulmonary tuberculosis. *Am Rev Tuberc Pulm Dis* 79:134-141, 1959.
2. Meyer EC, Liebow AA: Relationship of interstitial pneumonia honey combing and atypical epithelial proliferation to cancer of the lung. *Cancer* 18:322-349, 1965.
3. Berkheiser SW: Bronchiolar proliferation and metaplasia associated with bronchiectasis, pulmonary infarcts and anthracosis. *Cancer* 12:499-505, 1959.
4. Carroll R: The influence of lung scars on primary lung cancer. *J Path Bact* 83:293-297, 1962.
5. Walter JB, Pryce DM: The site of origin of lung cancer and its relation to histological type. *Thorax* 10:117-126, 1955.
6. Lisa JR, Trinidad S, Rosenblatt MB: Site of origin histogenesis and cytostructure of bronchogenic carcinoma. *Am J Clin Path* 44:375-384, 1965.



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ZINC: A Review of Current Trends in Therapy and Our Knowledge of Its Toxicity

GARY H. CASSEL, M.D.

Introduction

Many researchers have recently been advocating the use of zinc compounds for a wide variety of both medical and surgical problems. Little is actually known about the effects of long-term zinc therapy on man. This article is a review of the current trends in zinc therapy with a special emphasis on its toxicity.

Zinc Therapy: Past to Present

"Empirical topical use of zinc as calamine to promote healing dates back to about 1500 B.C. In the Ebers' papyrus (Ebers, 1875) recipes using calamine for certain eye salves are described. These recipes are cited in the translations by Joachin (1890) in German, and by Ebbell (1937) in English. Since that time, a variety of zinc compounds has been used in powders, salves, solutions, and ointments that have been employed very widely and effectively for the topical treatment of skin and eye lesions. These applications were reviewed by Wootton (1910).

"Systemic administration of zinc was practiced in Western Europe during the period of 1750-1850. Flowers of zinc (zinc oxide) and white vitriol (zinc sulfate) were employed for the treatment of convulsive disorders and similar syn-

dromes (Reuss, 1816) and later for the therapy of gleet (Graham, 1825). Although reportedly successful at first, zinc therapy fell into disfavor with the passage of years. Uncertainty of the composition of chemicals used for medication probably contributed greatly to the uncertainties."¹

In the past ten years, however, many have again expressed interest in human serum and total body concentrations of zinc. Beginning around 1969, Sullivan was one of the first investigators to demonstrate that many hospital patients are zinc deficient (serum zinc levels less than 90mcg/dl).² Others have also demonstrated hypozincemia in patients with alcoholism,³ atherosclerosis,⁴ chronic cutaneous ulcers,³ cirrhosis,³ Down Syndrome,³ dwarfism,⁵ lung cancer,³ leukemia,³ malnutrition,⁴ myocardial infarction,^{3,4} pregnancy,³ pulmonary infection (including tuberculosis),³ uremia,³ and chemotherapy.⁶

Further studies on zinc homeostasis in man have demonstrated that serum levels of zinc can also be affected by the zinc:phytate ratio in whole grain bread and cereal, the fiber content of diets, alcohol, sweat, blood loss, malabsorption, prolonged IV fluids, fasting, infection, nephrosis, chelating agents, surgery, other heavy metals, lactation, and genetics.⁷

With this mounting interest in the documentation of low serum zinc levels in many clinical situations, an interest in the effects of hypozincemia on man has also become a popular re-

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search topic. A syndrome of hypogonadism and dwarfism has been associated with zinc deficiency in Iran.^{8,9} Other studies have revealed this same deficiency state in Egypt,¹⁰ South Africa,¹¹ and the United States.¹² The latter was first evidenced in a study in 1972 of Denver school children from middle to upper income families who showed signs of symptomatic zinc deficiency (growth retardation, anorexia, and hypogeusia). Zinc deficiency has also been shown to have an adverse effect on the healing of surgical wounds¹³ and burns.¹⁴

Pories and Strain¹³ in an evaluation of zinc sulfate therapy in surgical patients stated the following, which is presented as evidence of the recent interest in zinc therapy and its future.

"Zinc deficiency is common in hospital patients and is characteristic of many chronic disease states. This deficit is probably a major factor in poor tissue repair and prolonged hospital stays. Fortunately, healing problems due to zinc deficiency respond well to zinc sulfate therapy, and the medication is well tolerated. Wider application of zinc therapy may be expected in the future as physicians become more aware of the zinc deficiency syndrome. Insufficiency states are already determined by atomic absorption spectroscopy, and inexpensive medication is now being evaluated.

"Further advances are dependent on establishing optimal levels for blood and other tissues of man, developing the interrelationships of the trace elements, and elucidating the mechanisms of zinc metabolism. Knowledge is especially needed on the availability of zinc from the diet and from the various body pools. Zinc deficiency is probably as common in man as Fe and Vitamin C deficiency, and appears to be of equal medical importance."

Zinc therapy mentioned by Pories and Strain has shown much promise in the area of surgical wound healing.¹⁵ This same type of treatment has also been used on patients with leg ulcers,¹⁶ burns,¹⁷ sickle cell anemia,¹⁸ decubiti,¹⁹ and atherosclerotic peripheral vascular disease.²⁰ These investigations have been very encouraging despite the difficulty associated with proving a

direct cause-and-effect relationship in such multifactorial conditions.

In reading through the current literature it seems evident that we have embarked on a new awareness of nutrition and its role in man. This is especially true for the trace metals, in particular, zinc, as has been illustrated above. From the very early uses of topical zinc we have now evolved into an era of systemic zinc therapy. Investigators have studied a wide variety of aspects concerning the clinical significance of zinc; however, in their wake they have left many important questions unanswered and yet unexplored, one of these questions being the effects of long-term supplemental zinc on man.

Zinc Toxicity

Research on the possible toxic effects of zinc on man has lagged behind the progress made in studying its other characteristics. A review of the literature over the past 50 years reveals sporadic accounts of isolated acute zinc toxicity and relatively little information on the effects of its long-term administration. Because of increased sophistication in laboratory measurements and a rising interest in the trace metals over the past ten years, much of the literature on zinc can be found to be concentrated within this brief time period. In the following accounts, however, earlier studies will be mentioned where applicable, but because of the differences in time and methods of analysis, the limits of comparison to current studies must be kept in mind.

Acute Zinc Toxicity—Inhalation

The topic of "metal fume fever" has consistently gained much attention over the past 50 years. Also known as brass founder's ague, zinc smelter chills, smeltershakes, furnace fever, galvo, Brasier's disease, etc., it was described by Batchelor et al in 1926 as "an acute febrile reaction, following the inhalation of freshly generated and, therefore, very dry and finely dispersed zinc oxide particle."²¹ The symptoms which result are systemic and temporary, resembling those of influenza. There is also an increased incidence during the winter.

The symptoms include fever, chills, muscular pain, nausea, vomiting, and headache, all occur-

ring over a period of approximately three to four hours (about four to eight hours after inhalation). These are then followed by sweating and general prostration. Other documented symptoms have been excessive salivation, gastrointestinal complaints such as colic, a sweetish taste, malaise, depression, and violent coughing attacks. Typically a high WBC count has been found, as well as increased urinary urobilinogens and an increased excretion of zinc. Complete recovery usually occurs in 24 to 48 hours. This episode characteristically produces a variable duration of "immunity" to future attacks. No evidence of residual disease or a predisposition to other respiratory disorders has been found. Dr. Batchelor (personal communication, 1972) noted that this condition was usually found to occur on Mondays in zinc smelting plants. He attributed this to the lowered "immunity" over the weekend or after vacations and the recurrence of the symptoms upon return to work after these days of absence.

Papp presented a case of a 31-year-old man

who developed "metal fume fever" after welding galvanized metal.²² In his discussion he describes a theory of etiology by McCord which implicates an antibody-antigen mechanism as the cause for the symptoms. The development of an *anti*-antibody has been postulated as the cause for immunity. Papp concludes by stating that much is still unknown about "metal fume fever" and that a better understanding is needed in order to aid in the future management of this medical entity.

A report on the effects of zinc-related compounds has been published after the deliberate inhalation of aerosol metallic paints containing Cu and Zn.²³ The observed symptomatology was a "flushed face, staggering gait, hilarity, and a spaced out look and demeanor; nausea and vomiting, and hallucinations." It is difficult, however, to assign these symptoms specifically to the increased levels of trace metals in the aerosols, as hydrocarbons were also present. Laboratory analysis, in this same report, revealed increased levels of copper as well as variable

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levels of zinc in 24-hour urine specimens of those involved. The article goes on to point out that there is a continuing misuse of this type of "high" and that there is a need for further study of the toxic effects which might be expected in those becoming addicted over long periods of time.

Acute Zinc Toxicity—Ingestion

Heller and Burke (1926) documented elevated levels of zinc in buttermilk stored in zinc containers.²⁴ Their concern over the toxic effects this might have on man led them to conduct a study on rats. Their study showed that there was no interference with growth or reproduction when supplements of zinc or zinc compounds were added to the animals' food. Pathological conditions were also not found in organs although total ash content of those organs studied showed a "perceptible increase." Studies since, however, have shown that there is a wide degree of species variation in zinc metabolism and homeostatic control.²⁵

More recently Gallery et al reported a case of acute zinc toxicity in hemodialysis.²⁶ They found a patient on dialysis at home was using rain water collected in a galvanized tank to dilute dialysis fluid. Symptoms of acute nausea, vomiting, and fever developed accompanied by severe anemia (Hb 3.5 gm). Plasma and RBC zinc concentration were found to be 700 and 3500 $\mu\text{g}/100\text{ml}$ respectively. It was actually not until these same symptoms recurred after the patient was sent home from the hospital that these investigators were able to diagnose zinc as the causative agent. Their article points out that recurrence could have been due to a type of "acute-on-chronic toxicity" and that the patient improved rapidly when deionization of her home dialysis water was carried out.

Other isolated cases of zinc toxicity related to ingestion include reports by Finney²⁷ and Murphy.²⁸ Finney reported on the need for total gastrectomy in an infant, secondary to the ingestion of "tinning paint." Murphy presented a case of a 16-year-old boy who after reading in *TIME* magazine (*TIME* 86:102 Nov 19, 1965) of the merits of zinc in promoting healing, ingested 12 grams of metallic zinc mixed with peanut butter. He developed lethargy accom-

panied by light-headedness, staggering gait, and difficulty in writing legibly (cerebellar dysfunction). The patient denied gastrointestinal distress, headache, tinnitus, paresthesias, or diplopia. Physical exam was normal; however, laboratory studies showed serum lipase values of 2.1 Cherry-Crandall Units (0-1.5, normal range) and serum amylase values of 286 Omnitek units (60-160, normal range). Treatment with BAL relieved symptoms. Pancreatic involvement has also been noted in experimental animal studies. Cats given large amounts of zinc supplementation for several months have been observed to develop small, nodular, "gritty" pancreases which contained large amounts of zinc.^{29,30}

In summary, the literature on acute zinc toxicity following ingestion is made up of scattered documentations on man and of a limited number of experimental studies on animals. Although the latter may provide an indication as to the possible effects of excess zinc on man, because of species variation accurate correlation is limited.

Toxicity by Direct Contact

Sources report that zinc and zinc compounds are well tolerated by the human skin. There are reports, however, of "poisoning" due to direct contact with zinc and zinc salts. A contact dermatitis secondary to zinc chloride exposure has been observed and may cause skin ulceration of the fingers, hands, or forearms in those who use it as a flux in soldering or in other occupations.³¹

Chronic Zinc Toxicity—Animal Studies

The effect of zinc excess in the diet has mainly been studied in experimental animals.^{31,32} Studies on rats have shown that excessive dietary zinc in these animals induces copper deficiency producing poor growth and anemia. These two effects of zinc toxicity can be partially mitigated by the administration of liver extracts and copper salts. A significant reduction in the level of liver iron, cytochrome oxidase, and catalase also has been noted in rats fed dietary supplements of zinc. Investigators believe that the anemia of zinc toxicity results first from an induced copper deficiency and, second, from an induced iron deficiency caused by an interference by high zinc

intakes with the absorption and utilization of these metals.

The effects of zinc toxicity on experimental animals is very variable. Sheep and cattle exposed to increased dietary zinc exhibited subnormal Cu levels, a less severe anemia than that observed in rats, and an increase in the liver iron concentration (in contradistinction to the decrease in liver iron seen in rats).

Experimental animal studies have also demonstrated pancreatic involvement in zinc toxicity, as has been previously mentioned. This finding is of particular interest in light of the elevated pancreatic enzymes observed in the case report by Murphy concerning the ingestion of elemental zinc.²⁸

Chronic Zinc Toxicity—Man

Batchelor et al (1926) in a study by the Harvard School of Public Health conducted a thorough review of the literature on chronic zinc toxicity in man up to that time.²¹ The one thing very evident from their writing is that there existed much controversy and speculation over this topic. Various authors claimed there were no toxic effects to long-term exposure to zinc while others cited chronic zinc "poisoning" as causing vomiting, intestinal colic, obstipation, emaciation, anemia, and, sometimes, muscular paralysis eventually leading to atrophy. Their review mentions several problems which contributed to this wide variation in observations, including the different quality of analytic techniques among investigators, the erroneous practice of using urine levels to comment on zinc toxicity, and the basic difficulty in separating the toxic effect of zinc from that of associated impurities (Pb, Cd, As, etc). In an attempt to accurately document effects on man of long-term exposure to zinc and its compounds, this group, in cooperation with a large zinc smelting operation in Pennsylvania, analyzed the health of 24 zinc smelter workmen exposed for from two to 35 years.

After a thorough evaluation of the health of the workmen Batchelor et al found "no acute nor chronic illnesses ascribable to zinc." They further stated: "Our study demonstrates that zinc workers absorb and excrete zinc in large amounts considerably over the normal, and they maintain

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constantly a blood zinc content slightly higher than normal.”²¹

Although conducted on a relatively small number of people and at a time when researchers did not have available the sophisticated analytical machinery of today, the results of the above study have been taken as conclusive proof by many authors over the past 50 years that there is no effect of long-term elevated serum zinc levels on man. Other researchers, however, still acknowledge the lack of information on this aspect of zinc. There is an expressed need for more research in this area, especially in light of current trends in zinc therapy and the recent evidence that long-term zinc supplementation in experimental animals causes poor growth and anemia.^{31,32}

Anada Prasad (1976), a well-known investigator of zinc deficiency, wrote: “In patients with sickle cell disease, in a limited trial, 660 mg of zinc sulfate has been administered orally for nearly one year without any adverse effects. On a longer-term basis, the side effects of zinc administration for therapeutic purposes remain to be elucidated. Physicians *must remain cautious* in the use of zinc sulfate for prolonged periods.”³³

Further emphasis as to our lack of knowledge in this area comes from Burch and Sullivan (1976): “At this time the long-term effects of excessive consumption of zinc have not been studied in humans. The effects of chronic excessive consumption of zinc in human beings on serum and urinary zinc levels or other biochemical parameters has (also) not been studied.”³⁴

Conclusion

Clinicians using trials of zinc therapy on their patients should be aware of the current lack of knowledge about zinc toxicity. This trace metal may very well prove to have a key role in medical and surgical therapy in the future. A cautious approach, however, is advocated until more research has been conducted into the effects of long-term zinc therapy on man.

REFERENCES

1. Pories WJ, Mansour EG, Plecha FR, et al: Metabolic factors affecting zinc metabolism in the surgical patient, in Prasad AS, Oberlasis D (eds): *Trace Elements in Human Health and Disease—The Nutrition Foundation*, vol 1, Zinc and Copper, New York, Academic Press, 1976, pp 115-141.
2. Sullivan JF, Parker MM, Boyett JD: Incidence of low serum zinc in noncirrhotic patients. *Proc Soc Exp Biol Med* 130:591-594, 1969.
3. Halsted JA, Smith JC Jr: Plasma zinc in health and disease. *Lancet* 1:322-324, 1970.
4. Pories WJ, Strain WH, Rob CG: Zinc deficiency in delayed healing and chronic disease. *Geol Soc Amer, Mem* 123:73-95, 1971.
5. Prasad AS, Oberlasis D: Zinc: Human nutrition and metabolic effects. *Ann Intern Med* 73:631-636, 1970.
6. Cutler EA, Palmer J, Kontras SB: Chemotherapy and possible zinc deficiency. *NEJM* 297(3):168-169, 1977.
7. Oberlasis D, Prasad AS: Factors affecting zinc homeostasis, in Prasad AS, Oberlasis D (eds): *Trace Elements in Human Health and Disease—The Nutrition Foundation*, vol 1. Zinc and Copper, New York, Academic Press, 1976.
8. Halsted JA, Ronaghy HA, Abadi P, et al: Zinc deficiency in man—the Shiraz experiment. *Am J Med* 53:277-284, 1972.
9. Prasad AS, Halsted JA, Nadimi M: Syndrome of iron deficiency, anemia, hepatosplenomegaly, hypogonadism, dwarfism, and geophagia. *Am J Med* 31:532-546, 1961.
10. Prasad AS, Miale A, Farid Z, et al: Biochemical studies on iron deficiency anemia, dwarfism, and hypogonadism. *Arch Intern Med* 111:407-428, 1963.
11. Hansen JDL, Lehman BH: Serum zinc and copper concentrations in children with protein-calorie malnutrition. *S Afr Med J* 43:1248-1251, 1969.
12. Hambridge KM, Walravens PA: Zinc deficiency in infants and preadolescent children, in Prasad AS, Oberlasis D (eds): *Trace Elements in Human Health and Disease—The Nutrition Foundation*, vol 1. Zinc and Copper, New York, Academic Press, 1976, pp 21-32.
13. Pories WJ, Strain WH: Zinc sulfate therapy in surgical patients, in Pories WJ, Strain WH, Hsu JM, Woosley RL (eds): *Clinical Application of Zinc Metabolism*. Springfield, Illinois, Charles C Thomas, 1974, pp 136-157.
14. Larson DL: Oral zinc sulfate in the management of severely burned patients, in Pories WJ, Strain WH, Hsu JM, Woosley RL (eds): *Clinical Applications of Zinc Metabolism*. Springfield, Illinois, Charles C. Thomas, 1974, pp 229-236.
15. Pories WJ, Henzel JH, Rob CG, et al: Acceleration of wound healing in man with zinc sulfate given by mouth. *Lancet* 1:121-124, 1967.
16. Greaves MW, Skillen AW: Effects of long-continued ingestion of zinc sulphate in patients with venous leg ulcerations. *Lancet* 2:889-891, 1970.
17. Larsen DL, Maxwell R, Abston, et al: Zinc deficiency in burned children. *Plast Reconstr Surg* 46:13, 1970.
18. Brewer GJ, Schoemaker EB, Leichtman DA, et al: The use of pharmacological doses of zinc in the treatment of sickle cell anemia, in Brewer GJ, Prasad AS (eds): *Zinc Metabolism*. New York, Alan R Liss, Inc, 1977, pp 241-254.
19. Herrmann JB: Design of large scale controlled studies of zinc therapy, in Pories WJ, Strain WH, Hsu JM, Woosley RL (eds): *Clinical Application of Zinc Metabolism*. Springfield, Illinois, Charles C Thomas, 1974, pp 181-194.
20. Henzel JH, Licht EL, Shephard W: Long-term oral zinc sulfate in the treatment of atherosclerotic peripheral vascular disease: efficacy of possible mechanism of action, in Pories WJ, Strain WH, Hsu JM, Woosley RL (eds): *Clinical Application of Zinc Metabolism*. Springfield, Illinois, Charles C. Thomas, 1974, pp 243-259.
21. Batchelor RP, Fehnel JW, Thompson RM, et al: A clinical and laboratory investigation of the effect of metallic zinc, of zinc oxide, and of zinc sulfide upon the health of zinc workers. *J Ind Hyg* 8(8):322-363, 1926.
22. Papp JP: Metal fume fever. *Postgrad Med* 43:160-163, 1968.
23. Wilde C: Aerosol metallic paints; deliberate inhalation. A study of inhalation and/or ingestion of copper and zinc particles. *Int J Addictions* 10(1):127-134, 1975.
24. Heller VG, Burke AD: Toxicity of zinc. *J Biol Chem* 74:85-93, 1927.
25. Ansari MS, Miller WJ, Lassiter JW, et al: Effects of high but nontoxic dietary zinc on zinc metabolism and adaptations in rats. *Proc Soc Exp Biol Med* 150:534-536, 1975.
26. Gallery EDM, Blomfield J, Dixon SR: Acute zinc toxicity in haemodialysis. *Br M J* 4:331-333, 1972.
27. Finney PC, Schnaeuffer L, Stafford ES: Total gastrectomy in an infant made necessary by ingestion of tinning paint. *Ann Surg* 151:891-895, 1960.
28. Murphy JV: Intoxication following the ingestion of elemental zinc. *JAMA* 212(12):2119-2120, 1970.
29. Scott DA, Fisher AM: Studies on the pancreas and liver of normal and zinc fed cats. *Amer J Physiol* 121:253-260, 1938.
30. Drinker KH, Thompson PK, Marsh M: An investigation of the effect of long-continued ingestion of zinc, in the form of zinc oxide, by cats and dogs, together with observations upon the excretion and the storage of zinc. *Am J Physiol* 80:31-64, 1927.
31. Van Reen R: Zinc toxicity in man and experimental species, in Prasad AS (eds): *Zinc Metabolism*. Springfield, Illinois, Charles C Thomas, 1966, pp 411-426.
32. Underwood EJ: *Trace Elements in Human and Animal Nutrition*, Third Ed, pp 208-252, New York, Academic Press, 1971.
33. Prasad AS: Deficiency of zinc and its toxicity, in Prasad AS, Oberlasis D (eds): *Trace Elements in Human Health and Disease*, vol 1. New York, Academic Press, 1976, pp 1-20.
34. Burch RE, Sullivan JF: Zinc, copper, and manganese abnormalities. *Med Clin NA* 60:658-660, 1976.

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PANCREATITIS WITH PSEUDOCYST:

A Complication of L-Asparaginase

Therapy for Leukemia

GARTH A. KONIVER, M.D.

JOHN E. SCOTT, M.D.

Pancreatitis as a toxic reaction to L-asparaginase therapy for acute leukemia and various other malignancies is well documented in the pediatric literature. Some patients have had no clinical symptoms,¹⁻⁶ while others were markedly symptomatic, pancreatitis being the cause of death.^{3,5} This is a case report of a pancreatic pseudocyst developing as a complication of L-asparaginase therapy for leukemia.

Case Report

The patient, a ten-year-old female with acute lymphocytic leukemia, was first diagnosed six years before. She achieved five previous remissions on various combinations of drugs. L-asparaginase had been started two months before the present admission; eleven weekly intravenous doses of 10,000 units each resulted in the sixth remission. She was admitted to Irwin Army Hospital, Fort Riley, Kansas, with a two-month history of vague, intermittent abdominal pain and a decreased appetite. Abdominal examination revealed left lower quadrant tenderness with rebound. Admission laboratory studies showed a white blood cell count of 1900 with a shift to the left. The hematocrit was 35%, the blood

glucose, 140 mg/dl. The BUN and serum amylase were normal; SGOT, LDH, and alkaline phosphatase were mildly elevated.

Three days later the white blood cell count was 1800, the hematocrit 29%; a bone marrow aspiration showed no relapse. Upper and lower gastrointestinal barium studies and excretory urography were normal. She continued to have intermittent pain complicated by severe constipation. Her dropping hematocrit was attributed to 6-mercaptopurine, which had been recently begun. It was discontinued, and a unit of blood transfused. Twelve days after admission, a repeat serum amylase was 503 Somogyi units (up to 180, normal). A two-hour urine amylase was 1500 Somogyi units (about 200 units per hour, normal), and a diagnosis of pancreatitis was made. L-asparaginase was stopped, and she improved moderately and was discharged.

She was readmitted one month later complaining of dizziness, headache, and midepigastriac pain. Initial physical examination revealed diffuse abdominal tenderness and left upper quadrant fullness. The hemoglobin was 6.8 gm/dl, and the hematocrit 19%. Excretory urography was normal. Upper gastrointestinal study showed evidence of a retrogastric mass. (Figure 1) She was transferred to Fitzsimons Army Medical

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This paper was prepared while the authors were serving at the Irwin Army Hospital, Fort Riley, Kansas.

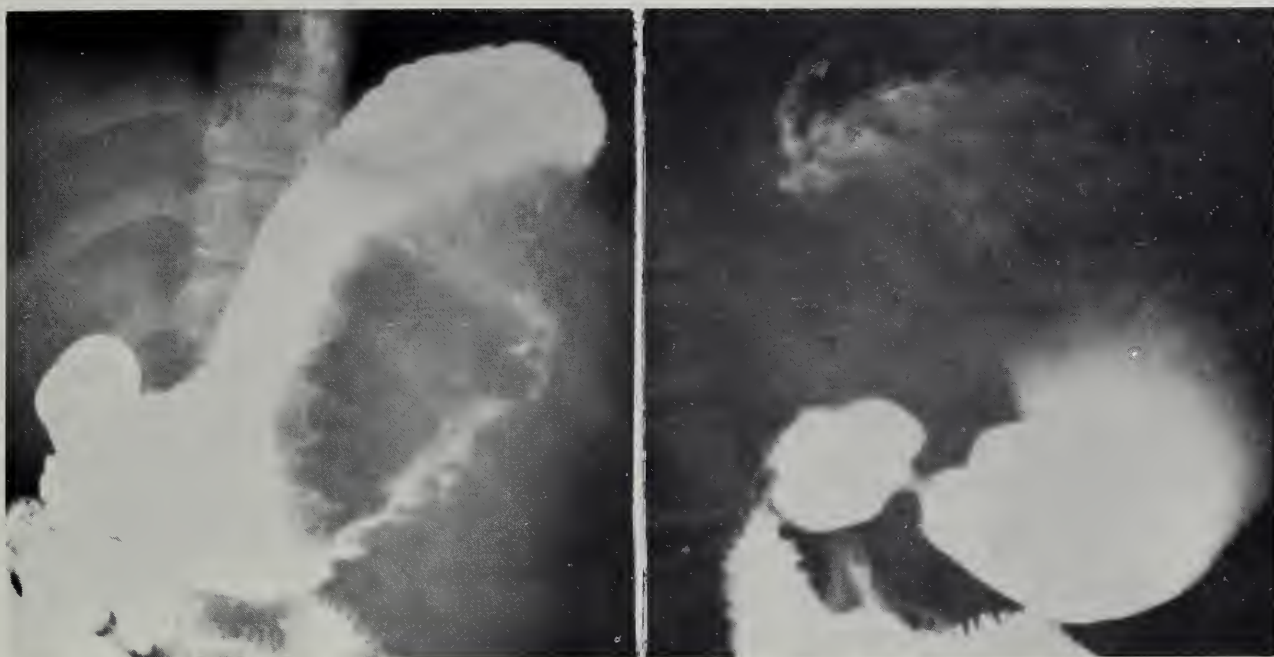


FIGURE 1

Upper gastrointestinal series from second hospital admission showing large LU Q mass with forward displacement of the stomach.

Center, where laparotomy revealed a grossly hemorrhagic pancreas with a pseudocyst posterior to the stomach containing a large amount of bloody fluid. Serum amylase prior to surgery was 228 Somogyi units. Postoperatively the patient did well and was discharged approximately one month later.

Discussion

L-asparaginase was first reported for the treatment of leukemia by Dolowy in 1966.⁷ Since then it has been utilized for many malignant conditions but primarily for the acute leukemias of childhood.⁸ The action of L-asparaginase is by the hydrolysis of L-asparagine; thereby sensitive cells lose the ability for protein synthesis. Two occasional, but life-threatening reactions are pancreatitis and anaphylaxis. Other reported toxicities are transient hyperglycemia, anemia, clotting abnormalities, liver dysfunction, azotemia, fever, nausea, anorexia, and central nervous system disturbances. The mechanism of the toxic reactions has not been definitely ascertained, but is probably related to L-asparagine depletion.^{7,8} The presence of glutaminase or an endotoxin is possibly a factor since L-asparaginase is extracted from *Escherichia coli*.¹⁰ Some

of the uncertainty exists because of the possibility of dose dependency. Although some authors feel the incidence of pancreatitis may be dose related,^{9,11} others do not. Haskell reported two cases with definite clinical signs of pancreatitis three and five days after initiation of therapy; pancreatitis was proven by autopsy.¹

The diagnosis of pancreatitis in the living patient is quite difficult. More than one-half of reported cases have been discovered at autopsy in asymptomatic patients with normal serum amylase values. Others have had an elevated serum amylase without clinical findings. A minority of patients have had clinical complaints and findings as well as elevated serum amylase values. Additionally there have been several reports of transient hyperglycemia^{9,12} with low levels of serum insulin demonstrated by two authors.^{9,10} Decreased synthesis or increased destruction is postulated. Since L-asparaginase is known to interfere with protein synthesis, the former is more likely. How, if at all, this relates to pancreatitis is not established.

Ultrasound has demonstrated pancreatic enlargement in five of eight patients on L-asparaginase and a pseudocyst in one of these.¹³ CT

Pancreatitis with Pseudocyst—Koniver

scanning would probably be useful also for early identification of these patients.

Summary

Our patient had both the clinical findings of pancreatitis and elevation of the serum amylase. The association of pancreatitis with 6-MP therapy has never been reported and is therefore extremely unlikely as an etiologic agent. The occurrence of a pseudocyst is, of course, not an unusual complication of pancreatitis, but has been previously reported in association with L-asparaginase therapy only once. Pancreatitis and its complications should always be considered in patients on L-asparaginase therapy since it is potentially life-threatening. Asymptomatic disease is actually not surprising with this condition. Strum and Spiro have stated that "most alcoholic patients have chronic pancreatitis at the time of the first attack" and that "painless pancreatitis is an entity."¹⁴ This would explain the high percentage of autopsy-discovered disease and alert us to this complication of L-asparaginase therapy in the minimally symptomatic patient.

REFERENCES

1. Haskell CM, Canellos GP, Leventhal BG, et al: L-asparaginase: therapeutic and toxic effects in patients with neoplastic diseases. *NEJM* 281:1028-34, 1969.
2. Jaffe W, Traggis D, Das L, et al: L-asparaginase in the treatment of neoplastic diseases in children. *Cancer Research* 31:942-949, 1971.
3. Land VJ, Sutow WW, Fernbach DJ, et al: Toxicity of L-asparaginase in children with advanced leukemia. *Cancer* 30:339-347, 1972.
4. Loeb E, Hill JM, Hill ND, et al: Treatment of acute leukemia with L-asparaginase. *Recent Results in Cancer Research* 33:204-218, 1970.
5. Oetting HF, Stephenson PA, Schwartz MK, et al: Toxicity of E. Coli L-asparaginase in man. *Cancer* 25:253-278, 1970.
6. Whitecar JJP, Bodney GP, Harris JE, et al: L-asparaginase. *NEJM* 282:732-734, 1970.
7. Dolowy WC, Henson D, Cornet J, et al: Toxic and antineoplastic effects of L-asparaginase: study of mice with lymphoma and normal monkeys and a report on a child with leukemia. *Cancer* 19:1813-1819, 1966.
8. Carbone PP, Haskell CM, Leventhal BE, et al: Clinical experience with L-asparaginase. *Recent Results in Cancer Research* 33:236-243, 1970.
9. Whitecar JP, Bodney GP, Harris JE, et al: L-asparaginase. *NEJM* 282:732-734, 1970.
10. Gailani S, Nussbaum A, Onuma T, et al: Diabetes in patients treated with asparaginase. *Clinical Pharmacology and Therapeutics* 12:487-490, 1971.
11. Zubred CG: The clinical toxicities of L-asparaginase in treatment of leukemia and lymphoma. *Pediatrics* 45:555-559, 1970.
12. Gillette PC, Hill LL, Starling KA, et al: Transient diabetes mellitus secondary to L-asparaginase Therapy in acute leukemia. *Journal of Pediatrics* 81:109-111, 1972.
13. Samuels BI, Culbert JC, O'Kamura J, et al: Early detection of chemotherapy-related pancreatic enlargement in children using abdominal sonography. *Cancer* 38:1515-1523, 1976.
14. Strum WB, Spiro HM: Chronic pancreatitis. *Ann Int Med* 74:264-277, 1971.

ADDITIONAL BIBLIOGRAPHY

- Hamilton-Fairley G, Malpos JS, Galton DA: Clinical experience with L-asparaginase. *Recent Results in Cancer Research* 33:257-262, 1970.
- Haskell CM, Canellos GP, Leventhal BG, et al: L-asparaginase toxicity. *Cancer Research* 29:974-975, 1969.
- Marmont AM, Damasio EE, et al: Some clinical observations on the treatment with L-asparaginase of the acute leukemia. *Recent Results in Cancer Research* 33:296-315, 1970.

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FINANCIAL INFORMATION PHYSICIANS SHOULD HAVE, PART I

LEIF C. BECK, LL.B., CPBC
VASILIOS J. KALOGREDIS, J.D.

A. Introduction

Medicine, as a profession, provides a great service to people; however, it is also a business. It is becoming more important than ever that physicians not ignore the business aspects of private practice.

We are amazed by the number of privately practicing physicians with little or no interest and/or knowledge of some of the most basic financial aspects of their practices. Undoubtedly, part of the reason for this lack of interest is the fact that medicine is a high-income profession. As many physicians themselves will admit, it is routine for doctors to earn a disproportionately comfortable living "in spite of themselves" as far as financial and business management is concerned.

As the cost-of-living continues to rise and governmental and insurance constraints proliferate, however, there will be increasing pressure on physicians to become more informed regarding their practice finances and efficiencies.

This two-part series will focus on the financial data a physician should want and expect to receive on a regular basis.

Messrs. Beck and Kalogredis are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd, Pennsylvania.

B. Monday Morning Report

A physician should receive weekly information on the practice's more important figures. We "practice what we preach" in this regard. Our bookkeeper prepares a weekly report for us at the end of each week to keep us fully informed on a timely basis.

A sample of a "Monday Morning Report" is included as part of this article. (Figure 1) Space is provided for eight weekly summaries. This is very helpful for comparison purposes. Many physicians have found it useful to punch holes in these sheets and place them in a looseleaf notebook for easy reference and comparison. This will help a physician and his advisors spot trends and hopefully ward off any difficulties before they become too serious.

Too often the problems inherent in a practice have gone unnoticed for a long period of time because weekly or monthly financial reports were not prepared or made available to the physician and his advisors. When the problem does surface, it is of crisis proportions and much more difficult to resolve.

The sample "Monday Morning Report" lists the cash in the bank and on hand as of the beginning of business on Monday morning and an

FIGURE 1

MONDAY MORNING REPORT				
CASH IN BANK AND ON HAND	\$			
ESTIMATED RECEIPTS (WEEK)				
TOTAL	\$			
ACCOUNTS PAYABLE:				
PAYROLL FOR WEEK	\$			
INSTALLMENTS OR LOANS				
OTHER CURRENT				
TOTAL	\$			
TOTAL ACCOUNTS RECEIVABLE				
INSURANCE FORMS PENDING				
CASH IN BANK AND ON HAND	\$			
ESTIMATED RECEIPTS (WEEK)				
TOTAL	\$			
ACCOUNTS PAYABLE:				
PAYROLL FOR WEEK	\$			
INSTALLMENTS OR LOANS				
OTHER CURRENT				
TOTAL	\$			
TOTAL ACCOUNTS RECEIVABLE				
INSURANCE FORMS PENDING				

estimation of the receipts for the coming week. In addition, bills payable are also summarized on the report so the doctor will know where the practice stands. Many (including ourselves) find it appropriate to separately attach a list of the bills outstanding. The doctor can peruse it and establish a payment priority list in light of the estimated income for that week.

The Accounts Receivable figure is included on the sample "Monday Morning Report." Many practices do not legitimately know what this figure is. In many instances the physicians are shocked when they find out how large the figure is. By putting the figure in front of the physician on a weekly basis any unusually large increases or decreases in receivable would be clearly noticeable. Any necessary corrective action could be taken promptly, in a timely and informed fashion, before the situation got any further out of hand.

Insurance forms pending is also an important category. Included within this would be the number of forms to be completed, the date of the oldest, and the approximate value of such

pending insurance forms. This is another area where medical practices have generally been very poorly informed.

The "Monday Morning Report" might also include other information. Some practices like to keep track of numbers of new patients, numbers of people admitted to the hospital, numbers of different types of visits, and the like. Each practice must determine what is most relevant and helpful to it. Once that is done, a weekly report can be developed to fit its needs.

C. Monthly Accounting Statement

An unfortunately large number of medical practices receive financial statements only on a quarterly, semi-annual, or even annual basis. To make things even worse, those reports often end up in the physician's hands many months after the fact. In light of that, they end up being little more than historical and of little help as a timely and effective management tool. This should be remedied.

Most accountants prepare formal financial statements for small medical practices. They generally provide a "balance sheet" setting forth the practice's assets and liabilities, and an "income and expense statement" showing the financial progress during the period from a profit and loss point of view.

Although they are helpful, these formal statements too often tend not to contain the information most useful to physicians and their advisors so that ongoing practice business decisions can be made. In addition, their infrequency (and in many cases, delay) and form (too lengthy for what is really needed and indigestible by the doctors in many instances) tend to make them less than totally helpful to the physicians for whom they are produced. In light of that, such a formal accountant's statement should be augmented by less official, more relevant, and more timely internal reports.

We believe that in-office monthly financial statements should be prepared. This should not be limited to large practices alone. A solo practitioner should also have this information at his fingertips.

In most instances this is best accomplished by making the practice's bookkeeper responsible for providing an informal monthly statement which will provide the doctor with the most useful and timely financial information of practice management value. The bookkeeper should be required to provide this statement within the first few days of any month (usually by the 10th) so that it can serve as a timely piece of information for quick review and thought by the physicians, the practice's office manager (if it has a manager at this level of management involvement), and the practice's advisors.

In group practices, we strongly recommend that the physicians hold a regularly scheduled monthly meeting to discuss practice management and financial matters. Such a financial statement would serve as an important agenda item at each doctor meeting. Having such relevant information before them and their advisors allows practices to avoid making decisions in a vacuum. It is all too common for physicians to end up having to discuss practice matters without having all of the relevant information. This should not be tolerated.

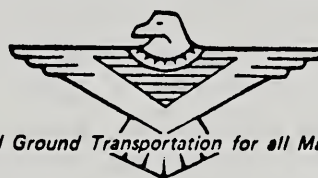
We are amazed and saddened by the number of medical offices we visit whose most recent financial information is a year or more old. To illustrate this, in March we visited a solo unincorporated physician. The only financial information he had for us to review was his practice's 1976 tax return. Obviously, it is difficult to deal with practice matters without more current information. It was particularly unfortunate in his case since the problems that had developed in that practice might have been averted, or at least diminished, if he had had more current information available. Such data would have "sounded the alarm" for corrective action before crisis proportions were reached.

Virtually all of the information necessary to prepare an in-house monthly financial statement is already produced by most practice bookkeepers. A practice's accountant or consultant usually trains the bookkeeper to summarize all receipts and to categorize all expenditures. A pegboard checkwriting system is particularly helpful and convenient in making the expense breakdowns in-house. The cost of preparing

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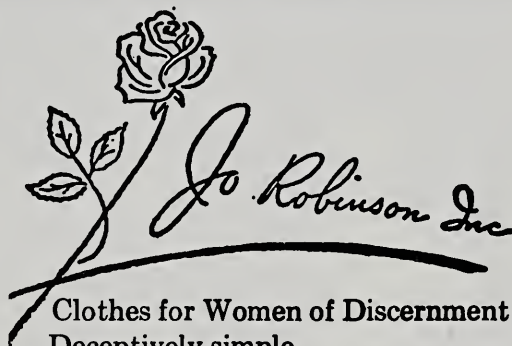
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such an in-house statement is well within the capabilities of the typical bookkeeper. One need not be an accountant to prepare this information.

Of course, an office should work closely with its accountant or consultant for assistance in preparing the monthly information form. In addition, a copy of the form prepared should be sent to the accountant, consultant, and/or attorney each month as a useful method of keeping them informed and more involved in the practice so that they can serve the practice better and more closely as good advisors. By allowing its advisors to review the statements, a practice is able to take advantage of their experience and capacities, for the physicians' benefit.

The statement form should be geared toward quick, concise, and complete presentation of information on a single sheet of paper. This will make it much easier for the doctor. It does avoid many of the hassles and difficulties doctors

have with the more formal, lengthier accounting reports usually received. A typically busy doctor quite often has neither the time nor the interest to review the more complex and lengthy financial reports.

If an office is on a computer service which provides reams of paper breaking down various charge, receipt, and expense items by many categories, it is still advisable for the bookkeeper to summarize on a single sheet the more important items from that computer printout. One of the great problems with the computer printouts themselves is that the physicians do not have the time nor interest to go through the many pages of summaries the computer sheets provide and make good and concise sense out of them. A simple reference sheet would be much more practical and useful to the physicians themselves.

A suggested style of such an in-house monthly financial statement will be included as part of next month's article.



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Whereas, the Medical Society of Delaware plans to launch a campaign during the month of June to encourage our citizens to take care of themselves; and

Whereas, this effort will be stressed with billboards, bumperstickers, and posters furnished by the Medical Society of Delaware under the general theme: "Your body -- abuse it and you'll lose it"; and

Whereas, an individual policy of self-discipline, exercise and good habits is one of the better ways of keeping healthy; and

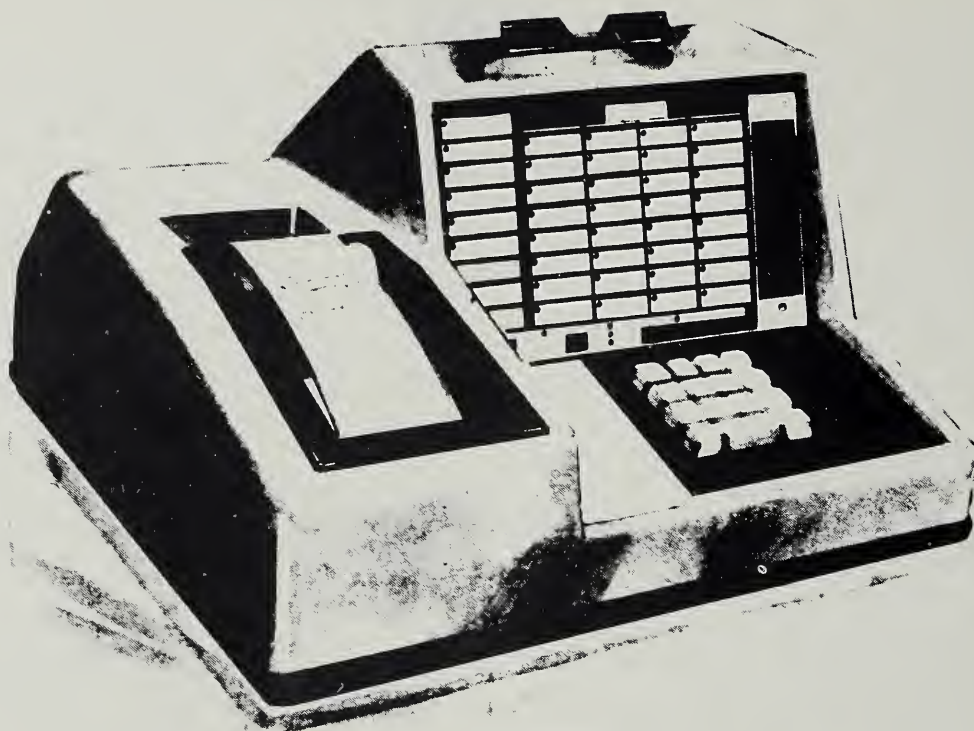
Whereas, it is in the best interest of all Delawareans to take better care of themselves;

Now, therefore, I, Pierre S. du Pont, Governor of the State of Delaware, do hereby declare the month of June, 1978, as

SELF-HEALTH MONTH

and urge all Delawareans to dedicate themselves to improving their health by observing the Medical Society of Delaware's worthwhile endeavor to promote better health not only during June, but also throughout the year.

A handwritten signature in dark ink, reading "Pierre S. du Pont".
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Editorials

THE MANAGEMENT OF IMPENDING MYOCARDIAL INFARCTION

Impending myocardial infarction, the prodrome of acute myocardial infarction, has also been called preinfarction angina, unstable angina, crescendo angina, and acute coronary insufficiency. The term implies that myocardial infarction, with its attendant morbidity and mortality, will develop in all instances. It does not make allowance for the wide spectrum of clinical situations that may portend but not necessarily progress to myocardial infarction.

Pathologically, in impending myocardial infarction and stable angina pectoris the location, distribution, and severity of coronary obstructive disease are identical. Two or three coronary vessels are involved in about 70%; a single coronary artery is affected in about 10%; and, curiously, normal, patent coronary arteries are found in about 10% of patients with this syndrome.

In about 25% of these patients, spontaneous coronary arterial spasm without coronary atherosclerosis is responsible for Prinzmetal's variant angina. The effect of the spasm varies from only moderate narrowing of the arterial lumen to almost complete obliteration. A small segment of the artery or its full length may be involved.

A number of studies have attempted to define the natural history of impending myocardial infarction. The conclusions drawn are questionable because of differences in definitions and failure to document the extent of vascular disease and ventricular dysfunction in each instance.

Mortality from coronary heart disease correlates well with the extent of disease as determined by selective coronary arteriography and ventriculography. The annual mortality is 20 to 30% with hemodynamically significant obstruction of the left main coronary artery, about 12

to 15% with three-vessel disease, about 6 to 9% with two-vessel disease, and about 4% with significant obstruction of the left anterior descending coronary artery. Obstruction of only the right coronary artery is consistent with an annual mortality of 2%; obstruction of only the left circumflex artery, with about 1.5%.

In patients with impending myocardial infarction, the prognosis is related to the degree of narrowing of the coronary arteries, the number of major vessels involved, and the degree of left ventricular dysfunction. The risk is extremely high in unstable angina pectoris caused by severe obstruction of the left main coronary artery. In contrast, the prognosis is excellent for patients with unstable angina pectoris and single vessel disease involving the right coronary artery or the left circumflex artery.

The object of treatment is to reduce myocardial oxygen requirements, to increase coronary blood flow, or to do both in order to prevent acute myocardial infarction. Hospitalization, bedrest, minimal caloric intake, and sedation are the standard measures used to reduce myocardial oxygen requirements. Hospitalization in a coronary care unit is necessary for optimal management. The beta-adrenergic blocking agent, propranolol, acts to reduce myocardial oxygen requirements by decreasing heart rate and contractile force. Nitrates, particularly when administered sublingually, act to decrease cardiac work by reducing blood pressure through venous and arterial dilatation.

Patients with the symptoms of impending infarction generally respond favorably to medical therapy. Coronary arteriography is not needed unless there are repeated bouts of pain so frequent and severe that they force consideration of coronary artery surgery. Surgery is advised

Editorials

for patients with unstable angina and left main coronary disease. Surgery is not advised for patients with less than 50% obstruction of the coronary arteries. Surgery is rarely advised for patients with the syndrome of impending infarction in whom only the right coronary artery or the left circumflex artery is obstructed.

BERNARD SEGAL, M.D.

Dr. Segal is Professor of Medicine, Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania.

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CHILD, INC. AND CARE

As a part of their project CARE (Child Abuse Reduction Effort), CHILD, Inc. (The Children's Health Institute and Learning Development)

has recently issued their study of suspected but unreported child abuse and neglect in Delaware. To someone unfamiliar with the incidence of the problem, it includes chilling statistics.

The final page of their report includes these sentences: "Children at risk and those who have already been victims of abuse and neglect constitute part of that valuable human resource pool which will form the Delaware community of tomorrow . . . A corps of citizens willing and able to speak out on behalf of these children could provide a much needed advocacy role."

Copies of the report are available from CHILD, Inc. at 905 N. Franklin Street, Wilmington, Delaware or telephone 655-3311.

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Letters to the Editor

To the Editor:

The following is part of the Presidential Address delivered by Howard T. Robertson, M.D. of Denver at the Annual Meeting of the Southwestern Surgical Congress in Acapulco, April 25-28, 1977. Dr. Robertson was also President of the Colorado State Medical Society in 1976. I think that it is very well written and would be of interest to your readership.

"No doubt because of the immense amount of money generated by the health care industry, the paraprofessionals are flexing their muscles and contributing to the confusion. The optometrist, for example, with a well-planned, well-executed, and well-financed campaign is mounting pressure on the state legislatures with mydriatic in one hand and cycloplegic in the other expressing righteous indignation that he is not allowed to practice ophthalmology merely because he has not observed the formalities of going to medical school, taking an internship, and completing a residency.

"The chiropodist has abandoned his corns and plantar warts for a higher calling and is patently aghast when it is implied that he should not be doing any surgical procedure, no matter how complex, below the middle third of the patella. The psychologist taunts the psychiatrist with his impressive (and expensive) biofeedback machine, and the chiropractor views himself as being part of the health care team and simply cannot believe that it is illegal for him to stick needles into people.

"It may appear on the surface that the squabbles within the medical profession and the aggressions of the paraprofessionals and cultists are of no consequence to the public and the lawmakers, but in truth many people are only

vaguely aware of the difference between the ophthalmologist and the optometrist, the psychiatrist and the psychologist, the chiropodist and the orthopedist, and some are even surprised to learn that the chiropractor does not have a medical degree. Thus, issues that affect the optometrist, chiropodist, and chiropractor affect us all, since we are viewed by some as being equals.

"It is ridiculous, of course, to believe that the physician can find a common ground with the cultist, but both the cultists and the paraprofessionals are here. They are a potent force, and confronting them head on in the newspaper or the court will result in some bloodied physician noses. Our position must be that we maintain constant vigilance through the State Medical Associations and keep our legislators informed when the cultists and paraprofessionals are obviously out of bounds. This must be done quietly, calmly, truthfully, legally, and with unflagging determination. The thin edge of the wedge is already visible; they have declared their hand, and in functioning beyond their capabilities they cause the patient to be the victim of substandard health care.

"Probably nothing we do will seriously affect the gyrations of the cultists. The paraprofessionals are ingrained in the system and we must live with them. But cultists and paraprofessionals aside, we in organized medicine must get our act together. We need to close ranks with the medical school, the hospital association, and the third-party carriers, and if we want favorable legislation we must select the legislation on which we can agree and back it in concert with our allies. We cannot agree on all issues, but the face we show to the legislature must be one that does not betray dissension with the other

component parts of organized medicine. We must jointly back the issues that accrue to the benefit of both our patients and the profession."

MIGUEL A. ARCACHA, JR., M.D.
Secretary-Treasurer
Delaware Academy of Ophthalmology

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To the Editor:

It's very unusual for me to write notes, but I was struck by Dr. Egan's comments on the President's Page in the April *Delaware Medical Journal*.

I think what he's saying is, get involved, and physician participation in the community, outside the profession, is minimal.

Even to a relative newcomer and youth it's becoming apparent that decisions are being made about us and for us when they should be made by us—or at least with our significant input. Our profession seems to be on the defensive regarding issues too much; we ought to be the initiators. Our active involvement outside the profession can only help our image, which too often looks tarnished or dulled.

I thought Dr. Egan's short essay was very effective.

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Book Reviews

NEUROLOGY by Mark Mumenthaler, translated by Edmund H. Burrows, Year Book Medical Publishers, Chicago, 1977. 452 pp. Price \$12.95. Paperback.

This small cloth-covered pocket edition looks like the many short and superficial summaries which seem to be flooding today's book market. As I glanced through the book and began reading it, however, I was pleasantly surprised for it is an excellent book. It is a short, succinct compendium of neurology that would be useful to medical students, house officers, internists, and even neurologists since it contains many "pearls" that neurologists should find of interest.

The author of this book is a leading authority in European neurology. The book contains many terms from 20-30 years ago that can be found no place else, or at least not in American neurologic parlance. There are many excellent charts and diagrams. It resembles a textbook much more than a simple review book, and is much more thorough than the text "Neurology for the House Officer" by H. L. Weiner and L. P. Levitt. It fits easily into the pocket of white coats.

Because of its low cost, high quality, and unique presentation of European neurology, I recommend it to all libraries and to all medical students, house officers, internists with special interest in neurology, and even to neurologists.

HOWARD LEIBOWITZ, M.D.

THE WHOLE PEDIATRICIAN CATALOG by Julia A. McMillan, M.D., Phillip I. Nieburg, M.D., and Frank A. Oski, M.D., W. B. Saunders Company, Philadelphia, 1977. 506 pp. Price \$12.95. Paperback.

A subtitle to this particular book might be, "A Guide to the Perplexed." It is not a complete text by any means but rather a simple, very well designed outline of the main diagnostic features of most pediatric problems. The authors have done a commendable job in re-

moving much of the exotic dead wood cluttering up the forest, enabling the trees to be seen. The more commonly encountered diseases are reviewed, leaving esoterica to the more comprehensive texts in the field.

There are 20 chapters. The amount of space devoted to one subject varies from only a few sentences to a single page. For example, asthma in childhood, a topic frequently encountered in the office of a primary care physician, is disposed of rapidly by 14 lines of large type and three charts, which could probably be condensed into two pages rather than the three pages used.

The text's primary drawback is its lack of mention of treatment modalities for the diseases discussed. All in all, I recommend the book as one that could very easily be used to review the basic pediatric problems which keep cropping up with a great degree of frequency in any practice which includes kids.

ETHAN FLAKS, M.D.

1977 YEAR BOOK OF CARDIOLOGY edited by W. Proctor Harvey, M.D., Year Book Medical Publishers, Chicago, 1977. 500 pp. Illus. Price \$24.50.

Cast in the usual format of the Year Book series, this volume contains summaries of papers published from late 1975 through late 1976. Both subject and author indices are included. The format of the book centers on eight major topics, each arranged by a single editor. A basic abstract of each article is presented, and then the section editor provides commentary liberally supported by further references.

In addition to providing interesting reading (the instant critique of each paper by the section editor provides good balance), the book is an excellent source for a quick review of the more rapidly evolving topics in cardiology, topics which range from basic physiology through therapy.

The book is loaded with information, yet probably many readers will feel compelled to read the original article if they find an abstract particularly interesting. Most physicians who care for patients with cardiovascular problems would benefit from reading it.

MICHAEL STILLABOWER, M.D.

TOUCHING ALL BASICS—FUNDAMENTAL PROBLEMS IN EMERGENCY CARE edited by Irving J. Cohen, E.M. Books, New York, 1974. 230 pp. Illus. Price \$14.00.

This book is a collection of articles from *Emergency Medicine*. The editors tried to pick those articles which "deal *especially* effectively with a common and *fundamentally* important clinical problem in emergency care." The 34 articles, each up-dated as some were first published in 1969, deal with various aspects of anaphylaxis, bleeding, cardiovascular distress, drug abuse, infection, neurologic emergencies, OB-GYN crises, poisoning, psychiatric emergencies, respiratory distress, and trauma.

I thought some of the selections too basic, but many others are quite good. The papers in the section on trauma stand out for their clarity and usefulness. This is not a book that all physicians who encounter emergencies must read, but it does contain a large quantity of fundamental information in a format which can be easily assimilated.

ROBERT H. HALL, M.D.

TEXTBOOK OF GYNECOLOGY by Russell Ramon De Alvarez, M.D., Lea & Febiger, Philadelphia, 1977. 546 pp. Illus. Price \$42.50.

In his preface, Dr. De Alvarez, Professor of Obstetrics and Gynecology at Temple and Chairman Emeritus of the department, says, "This text represents a careful effort to develop a reference text for physicians who deal with the gynecologic patient. Authoritative papers by 29 contributors emphasize diagnosis and treatment to serve the requirements of the gynecologic specialist."

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I think it is a useful text for non-gynecologists as well. Four random observations: The colored pictures of cytologic specimens are especially good. Dr. Labrum considers most non-orgasmic women to be expressing anger towards their husbands. The scanning electron microscope certainly makes pretty pictures of things like the cilia in oviducts. And why must medical textbooks be so expensive?

ACCENT ON LIVING BUYER'S GUIDE edited by Betty Garee, Accent Special Publications Cheever Publishing, Inc., Bloomington, Illinois, 1978. 70 pp. Illus. Price \$10.00. Paperback.

This small paperback with a big price tag describes itself as "an indispensable guide to independence." It lists a variety of products to improve the comfort and general activity abilities of the disabled. For example, there are shower lifts, flexible and knotless shoelaces, Portascoots (front wheel drive electric scooters), breath-controlled wheelchairs, electric page turners, and even a long-handled suppository introducer to

allow "independent toileting for both paras and quads." I think most disabled persons would like to have their own copy as should all who counsel disabled persons. Accent also publishes a quarterly magazine for the disabled, \$3.50 a year.

TO BE AN INVALID THE ILLNESS OF CHARLES DARWIN by Ralph Colp, Jr., M.D., The University of Chicago Press, Chicago, 1977. 285 pp. Price \$17.50.

Darwin was a vigorous young man during his three years traveling around the world as the HMS Beagle's naturalist. Yet after returning home to England, the young man who had spent weeks riding alone across the Argentinian pampas spent most of the rest of his life disturbed and inconvenienced by a number of recurrent symptoms, including severe fits of flatulence which he regularly noted in his Diary of Health as "fits of ft."

Others have suggested that Darwin had diseases as varied as chronic arsenic poisoning,

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Chagas disease (trypanosomiasis), which he picked up while traveling with the Beagle, rheumatic fever, cholecystitis, chronic depression, peptic disease, narcolepsy, hyperinsulinism, porphyria, and allergy to pigeons.

Dr. Colp proffers still another suggestion. Darwin "became ill after realizing the consequences of his evolutionary thoughts; this illness indicated that he was emotionally and physically sensitive to the difficulties of his evolutionary theory and to being hated and rejected," says Colp, Director of Psychiatry at Columbia University Student Health Services.

Colp has apparently read everything Darwin ever wrote during his long life and just about everything ever written about him. Even if one disagrees with his theory, Colp's meticulous scholarship must be admired; he provides hundreds of references.

BERNADINE Z. PAULSHOCK, M.D.

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A RADIOGRAPHIC INDEX by Meyer Goldman, M.D. and David Cope, F.S.R., 5th ed., Year Book Medical Publishers, Chicago, 1975. 90 pp. Price \$7.95.

This book is presented as a short practical guide to radiographic positioning and procedures, of particular value to radiologic technologists, technology students, and to radiology residents.

Its contents include positioning instructions for various radiographic procedures listed alphabetically, and short appendices dealing with contrast media, medical terms, common abbreviations, average exposure tables, named views of skull, and normal blood values.

The book's major assets are its small size (11 x 17 x 1 cm thick), which allows it to be carried in the uniform pocket, and its satisfactory description of basic positions for routine radiography.

The major drawbacks of this book are differences in terminology (the authors are English) and, in the case of most special procedures and

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Book Reviews

contrast examinations, significant differences in technique.

The book has an initial appeal on a "security blanket" level. However, because of the above-mentioned disadvantages, the availability of more comprehensive (albeit larger) texts on radiography in most departments, and the availability of experienced fellow technologists and radiologists in most radiology departments, it would probably be used much less by the purchaser than originally anticipated.

JOHN S. WILLS, M.D.

THE MEDICAL MANAGEMENT OF THE SURGICAL PATIENT by F. G. Smiddy, M.D., Year Book Medical Publishers, Chicago, 1976. 280 pp. Price \$18.95.

Dr. Smiddy has written this book to remedy a defect which he detects in the general medical knowledge of surgeons. Unfortunately, this book fails miserably. It is so unbelievably bad that as a reviewer I hardly know where to start.

The format is of a cookbook type, and if I did not know how to treat a disease, I would be no

better off after reading this book. There are misstatements such as, "As the patient becomes more acidotic an increasing amount of sodium is taken up by the aceto-acetic acid leaving the bicarbonate ion in isolation" (p.14), or on p. 74, "The normal heparin regime controlled by measurements of the prothrombin time." On p. 76 he recommends heparin to be started with streptokinase. I think that will give the reader enough information to judge this text.

In addition to the above, the references are frequently out-of-date. An example will suffice. In the discussion of peptic ulcer one non-essential reference was from 1972, the rest from the 1950's and 1960's with a good sprinkling from the 1940's. There is no mention of cimetidine or discussion of H₂ receptors. In treatment of shock dopamine is omitted; aspirin is cited as a cause of G.I. bleeding, but no mention is made of its platelet effects, certainly an important fact for a surgeon.

Finally, many of the drugs mentioned are not available in this country, and for many others the names are unfamiliar. Sadly, I cannot recommend this book to anyone.

LEONARD P. LANG, M.D.

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In Brief

Speakers on "Ask the Doctor" Speakers for July 1978 on the Tuesday radio program (11:05 a.m., WDEL) produced by the Medical Society of Delaware are: July 11, *Marvin Andersen, M.D.*, Sterilization; July 18, *James Reamer, M.D.*, Laboratory Tests; and July 25, *Maurice Thew, M.D.*, Skin Cancer.

In the News *Vidya V. Sagar, M.D.* of the Veterans Administration Center, Wilmington, has been elected president of the Delaware Society of Nuclear Medicine. *Robert L. Meckelnburg, M.D.* of the Wilmington Medical Center is secretary and treasurer. The Kent County unit of the American Cancer Society has elected *O. Keith Hamilton, M.D.* president for the coming year. *Wellford Inge, M.D.* will be the new vice president.

Governor duPont has made the following appointments to the Board of Medical Practice: *Vincent G. J. Lobo, Jr., D.O.* of Harrington (reappointment), *Thomas E. Dyer, M.D.* of Milford, and Mr. Gilbert Pinkett of New Castle. All terms are for three years.

Snake-Bite Antivenins The Antivenin Index Center is a current catalog of snake-bite antivenins stocked in North American zoos, laboratories, and related institutions. The Center provides a 24-hour retrieval service on antivenins available for the treatment of venomous snake-bite from native and exotic species. The Center does not stock antivenin; rather, it serves as an index for emergency information. To use this service, obtain both the scientific (genus and species) and the common or vernacular name of the snake involved and call the Antivenin Index Center in Oklahoma City at (405) 271-5454.

National Research Program The American Heart Association will present the 1979 National Research Program CLINICAL SCIENTIST AWARD in the cardiovascular field including stroke and for related problems. Applicants must have an M.D. or equivalent degree and ordinarily be under age 35 at the time of award activation. Awardees will be supported during an initial two- to three-year period of rigorous full-time research experience and during a subsequent period in which they will be expected to initiate an independent investigative program. The application deadline is August 15, 1978 (for award activation July, 1979). For information and application forms contact: Director of Research, American Heart Association, 7320 Greenville Avenue, Dallas, Texas 75231.

CLINICAL NOTICES AND MEETINGS

Meeting of Oral and Maxillofacial Surgeons The 60th ANNUAL SCIENTIFIC SESSION OF THE AMERICAN ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS (AAOMS) will be held September 15-19, Chicago, Illinois. For information contact: AAOMS, 211 East Chicago Avenue, Suite 930, Chicago, Illinois 60611.

Hand Injuries The American Society for Surgery of the Hand will present PRIMARY CARE OF HAND INJURIES, September 28-October 1, Sea Island, Georgia. For information contact: Gail M. Gorman, Administrative Director, American Society for Surgery of the Hand, 2600 S. Parker Road, No. 233, Aurora, Colorado 80014. Telephone: (303) 755-4588.

ASIM Meeting The American Society of Internal Medicine will hold its INTERIM MEETING, September 29-30, Orlando, Florida. For information contact: ASIM, 535 Central Tower Building, 703 Market Street, San Francisco, California 94103. Telephone: (415) 777-1000.

AHA Course

The American Heart Association will present ISCHEMIC & MYOCARDIAL HEART DISEASE/BASIC REVIEW, RECENT ADVANCES & CURRENT CONTROVERSIES, July 6-8, Lake Placid Club, Lake Placid, New York. The program is acceptable for 14 hours in Category I of the Physician's Recognition Award and 14 elective hours by the American Academy of Family Physicians. For information contact: American Heart Association, Attn: Scientific Sessions, 7320 Greenville Avenue, Dallas, Texas 75231.

Cancer Conference

The American Cancer Society, Colorado Division, and the Colorado Medical Society will present the 32nd ANNUAL ROCKY MOUNTAIN CANCER CONFERENCE, July 14-16, The Broadmoor Hotel, Colorado Springs, Colorado. The program meets the criteria for 12 credit hours in Category I of the Physician's Recognition Award. For information contact: Rocky Mountain Cancer Conference, 1809 East 18th Avenue, Denver, Colorado 80218.

General Diagnostic Radiology

The New York University Post-Graduate Medical School will offer a seminar, GENERAL DIAGNOSTIC RADIOLOGY, September 25-29, at the Roosevelt Hotel, New York City. The program is accredited for 28 hours of AMA Category I. For information call or write: NYU Post-Graduate Medical School, 550 First Avenue, New York City, New York 10016, (212) 679-8745.

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Classified advertisements of a professional nature are free to members.

PSYCHIATRIST: University of Delaware Student Health Service seeks an M.D. with completed psychiatric residency for a 9-month, half-time position assisting the full-time University psychiatrist in providing direct services to students. Position is available September 1, 1978. For information contact: C. Ray Huggins, M.D., Director, Student Health Services, Laurel Hall, University of Delaware, Newark, Delaware 19711.

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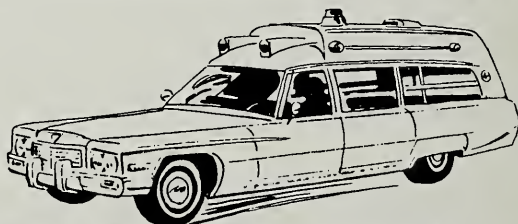
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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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cancer communiqué

FROM THE DELAWARE CANCER NETWORK*

WHEN DO YOU CALL A CHAPLAIN?

THE REVEREND CARL R. SACHTLEBEN

A formal hospital chaplaincy program began recently at Kent General Hospital, Dover, Delaware. The program was created to help meet the spiritual and emotional needs of people who are hospitalized. A staff of twelve pastors from Dover area congregations have volunteered to serve on the chaplaincy staff. In this capacity they have agreed to be on a 24-hour call for emergency situations, to respond to all patient requests for their service, and to receive referrals from physicians and nurses. These pastors prepared themselves for this task through a three-month seminar co-sponsored by the hospital, the Dover Clergy Association, and the Delaware Cancer Network.

As these pastors began their work as chaplains in the hospital, a number of physicians asked the chaplains, "When do we refer a patient or family to you?" Some of the physicians said immediately that they were reluctant to suggest a chaplain to a patient because many patients would fear the presence of a chaplain. The physicians went on to elaborate that the fear they spoke of was the patient's association of the presence of a chaplain with approaching death.

The Roman Catholic chaplain understood what the physicians were saying because he was often called upon to administer the Sacrament of the Last Rites to patients who were dying.* But to many of the Protestant chaplains, this was somewhat surprising. Before the advent of the hos-

pital chaplaincy program, these same pastors had regularly made pastoral visits at the hospital; however, they had come in the capacity of a parish pastor and visited only members of their own congregation. Those congregational members understood their pastor's visit to be part of the larger and more longstanding relationship of pastor/parishioner and did not immediately associate his visit with the possibility of impending death. In their new capacity as hospital chaplains, however, they would most likely encounter this patient perception and association of the chaplain with impending death.

An interesting study of patients conducted by the Department of Pastoral Care at Lutheran General Hospital, Park Ridge, Illinois, confirmed this patient attitude. Randomly selected patients from two nursing units who did *not* ask for a chaplain during their hospitalization were asked to imagine under what conditions they would call a chaplain. In all instances, when pressed, the patients stated that if they would call a chaplain, it would be in a time of serious illness when the prospect of death was imminent. The study concluded by suggesting that it was very important for chaplains to be aware of the role expectation conflict and to clarify their role with patients and staff.*

So, the question of when to call a chaplain is certainly important. I would like to suggest four times in which a chaplain might be most helpful:

*At the Second Vatican Council, this sacrament was renamed and is now known as the Sacrament of the Anointing of the Sick. It can be administered frequently to the sick and aged and is not reserved for the time of death.

Mr. Sachtleben is Coordinator of Pastoral Services for the Delaware Cancer Network.

*Hartung, Bruce M: "The Initial Call," *Toward a Creative Chaplaincy*, Lawrence E. Hoist, ed. Springfield, Illinois, Charles C. Thomas, 1973.

*An NCI-supported agency located at 1200 Jefferson Street, Wilmington, Delaware 19801. Tel. (302) 428-2113.

Cancer Communiqué

- (1) When a patient asks for a chaplain
- (2) When the patient is experiencing difficulties
- (3) When the family members are experiencing difficulties
- (4) During terminal illness

In each of these situations the goal of the chaplain is to help the patient utilize his personal strengths and religious faith to enable him to cope with the life crisis through which he is going.

That some patients will strongly associate the work of chaplains mostly with the time of death, is understandable. Chaplains do work with the dying, with the surviving family members, and with the staff who care for the patient. But they are available and helpful in other ways too. The challenge for the chaplains at Kent General is to continue to be aware of this role conflict and to take every opportunity to interpret *all* of their work to patients and staff; however, they cannot do this alone and will need the support and help of other staff members in this task.

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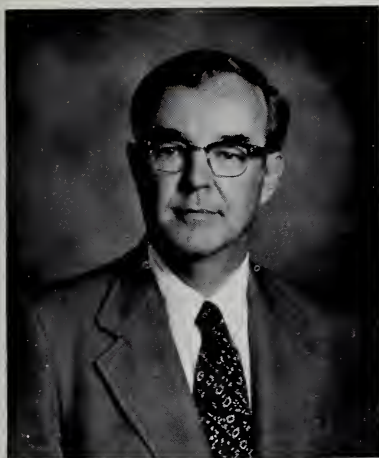
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President's Page

ABORIGINES, MUMMIES, MURDER, COMA, AND EVOLUTION

I look forward to all members of our profession participating fully in the activities and discussions that are part of our annual meeting, to be held this year on September 23 at the Hotel duPont.

This will be the 189th meeting of the Medical Society of Delaware, making it one of the state's most venerable and continuing institutions. As in past years our meeting opens with a prayer breakfast. This year's program promises to be one of our most interesting ever. All of you should have received your flyers reminding you that pre-registration is required and advising that subjects both esoteric and exciting such as "aborigines, mummies, murder, coma, and evolution" will all be under scrutiny during the course of the meeting.

The luncheon speaker, Robin Cook, M.D., promises to be especially interesting, as he comments on his dual careers as physician and author in which latter capacity he created the best-selling novel, *COMA*, and then wrote the movie script.

Others on the program are equally appealing. Nobel Laureate Baruch S. Blumberg, M.D., Ph.D., discoverer of the Australia Antigen, will discuss his work with that country's aborigines; James E. Harris, D.D.S., M.S., will reveal the secrets of the mummies which have unfolded during his studies of Egyptology; George F. Ca-

hill, Jr., M.D., will give his fascinating thoughts about "evolution and diabetes" from his vantage point as professor of medicine at Harvard; and Wilton H. Krogman, Ph.D., will describe his 40-year career in forensic anthropology which includes professional assistance to the production of Elliott Ness's "Untouchables."

There will be an important special program for the spouses of physicians designed to help them advance your career and improve the work of our Society. Entitled "Assertiveness: Techniques of Effective Communication," it will include a workshop conducted by Mrs. Susan Drury, clinical psychologist at the University of Delaware.

So the program is there. Those who attend should find it both useful and fascinating.

And since all of us know that the Hotel duPont is justly renowned for its decor and cuisine, the elements of a busy, warm, and glorious day culminating in our elegant dinner-dance are all put together just for you.

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CARDIAC MURMURS: INNOCENT OR ORGANIC?

BERNARD L. SEGAL, M.D.

MORRIS N. KOTLER, M.D.

WILLIAM LIKOFF, M.D.

Murmurs are noises. They consist of vibrations of varying frequency, intensity, quality, and duration produced by structural and hemodynamic abnormalities.

Heart murmurs are primarily classified on the basis of their timing. Systolic murmurs begin with or after the first heart sound, and end at or before the second heart sound. Diastolic murmurs accompany or follow the second heart sound and terminate at or before the first heart sound. Both systolic and diastolic murmurs are also qualified by the terms early, mid, and late to indicate their exact point in the cardiac cycle. Continuous murmurs extend from the first through the second heart sound, ending at or before the next first heart sound.

SYSTOLIC MURMURS

The intensity of systolic murmurs is generally graded from 1-6, with the lowest number representing the softest murmur. This is not entirely objective, but it is far preferable to rating intensity as slight, moderate, or marked. A grade 1

murmur is so faint that it can be heard only with difficulty. Grade 2 murmurs are soft but can be recognized more readily. Grades 3 and 4 identify progressive increases in the intermediate ranges of intensity. Grade 5 indicates a very loud murmur, differentiated from grade 6 in that the latter is still audible with the stethoscope just removed from the chest wall.

It is difficult to evaluate objectively the quality of murmurs. Adjectives such as musical, blowing, rough, and twanging have specific meaning only for the examiner who uses the terms. It is more helpful to define the character of a murmur in terms of the variation in amplitude of its vibrations during a single cardiac cycle. The murmur is said to be crescendo when the amplitude increases progressively. Conversely, if it decreases, it is described as decrescendo. Murmurs may also be crescendo-decrescendo; the graphic registration of these is diamond-shaped. Duration of murmurs is adequately described as either long or short.

For systolic murmurs two qualifying terms are used to convey information about timing, quality, and duration. An ejection systolic murmur is midsystolic. It begins after the first heart sound, is usually crescendo-decrescendo, and ends be-

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fore the second heart sound. A holosystolic murmur begins with the first heart sound, extends through all of systole, and is characterized by the uniform amplitude of its vibrations. Loud murmurs generally radiate from their site of maximal intensity. The direction of radiation may provide useful information regarding the origin of the murmur.

Midsystolic Murmurs

Ejection midsystolic murmurs are caused by aortic or pulmonary valve stenosis, roughening of these valves without stenosis, outflow tract obstruction in either the right or left ventricle, post-stenotic dilatation of the aorta or pulmonary artery, increased velocity of blood flow as in hyperkinetic states, or any combination of these conditions. They are also observed in normal healthy subjects.

The midsystolic murmur of aortic stenosis is heard best at the second interspace to the right of the sternum. Its intensity is determined by the degree of obstruction at the aortic valve. When the obstruction is mild or when left ventricular output is seriously impaired, the murmur may be only grade 1 or 2. With a high degree of stenosis and an adequate cardiac output, the murmur's intensity increases and a thrill may be felt across the base of the heart. The duration of the murmur also increases as aortic stenosis progresses from mild to severe, as long as cardiac output is not seriously reduced. Because of the proximity of the carotid vessels to the origin of the murmur, the murmur of aortic stenosis is transmitted well along the carotid vessels even when its intensity is not great.

These murmurs may also be transmitted down the left sternal border and to the apex where they are usually less intense. The physician should palpate the carotid pulse. In patients with significant aortic stenosis, a thrill is felt, and the pulse is characteristically of poor volume with a slow upstroke and an abrupt halt, suggesting the anacrotic shoulder. A systolic thrill may be palpable at the aortic area in the second right interspace, and the left ventricle is felt over the apex.

The murmur of aortic stenosis should be differentiated from the murmur of idiopathic hyper-

trophic subaortic stenosis. The murmur is heard best along the left sternal border in patients with IHSS. It becomes louder with the Valsalva maneuver as the obstruction increases in the outflow tract of the left ventricle. Unlike the carotid pulse in aortic stenosis, the pulse of IHSS is of high volume with a rapid jerky upstroke. The echocardiogram is of great value in differentiating IHSS from aortic stenosis.

A short and soft midsystolic murmur is also heard in patients with aortic dilatation, with aortic valve sclerosis in the elderly, and in patients with hypertension and a dilated aorta. The chest x-ray will show aortic aneurysm.

The midsystolic murmur of papillary muscle dysfunction is generally best heard along the lower left sternal border and at the apex. The intensity varies according to the degree of mitral regurgitation and the turbulence created across the mitral valve. It is heard in patients with coronary heart disease and cardiomyopathy.

A midsystolic murmur originating from the right side of the heart is associated with pulmonary valvular stenosis, or stenosis above or below the pulmonary valve. The murmur of pulmonary stenosis is best heard in the second left interspace and radiates upward into the left chest. It may be heard in the suprasternal notch or at the base of the neck, usually on the left.

The greater the obstruction across the pulmonary valve, the longer the systolic murmur. Abnormally wide splitting of the second heart sound, which is best heard at the pulmonary area, is a hallmark of pulmonary stenosis. A systolic thrill may be felt over the upper left sternal border; a systolic thrust over the sternum represents right ventricular hypertrophy.

The midsystolic murmur of an atrial septal defect should be differentiated from the murmur of pulmonary stenosis. In the patient with an atrial defect, the midsystolic murmur is best heard at the pulmonary area in the second left interspace; abnormally wide but fixed splitting of the second sound is noted. The degree of splitting of the second sound at the pulmonary area does not increase with inspiration.

The murmur of tetralogy of Fallot is produced by turbulence across the pulmonary valve or in the outflow tract of the right ventricle. In severe

tetralogy, the patient is cyanotic as blood is diverted from the pulmonary circulation and passes by way of the ventricular septal defect into the aorta. The intensity of the murmur is soft. In patients with mild tetralogy, cyanosis may be absent, and the murmur is loud since the total right ventricular blood volume passes into the pulmonary artery rather than through the ventricular defect into the systemic circulation. Thus, in contrast to pulmonary stenosis, in tetralogy of Fallot the louder the murmur, the less significant the lesion.

Midsystolic murmurs are heard in patients with hyperkinetic states such as hyperthyroidism, severe anemia, pregnancy, beri-beri, cor-pulmonale, or fever. They are also heard in normal healthy subjects during exercise. The murmur is generally soft (grade 2), and heard best at the second and third left sternal border. These murmurs are probably caused by turbulence set up by increased velocity of flow through the outflow tracts of either ventricle.

A soft and short midsystolic murmur may be innocent. The innocent vibratory murmur of Still is a short, buzzing, regular-frequency murmur that probably originates from vibrations of the pulmonary valve. Another innocent pulmonary midsystolic murmur, which occurs in children, adolescents, and young adults, appears to be an exaggeration of normal ejection vibrations in the outflow tract of the right ventricle. In contrast to the vibratory Still murmur, the innocent pulmonary systolic murmur is higher pitched, tends to have a blowing quality, and is generally short and soft. The second heart sound at the pulmonary area splits normally, becoming a trifle wider on inspiration than expiration. The carotid and venous pulses in the neck are normal. There are no abnormal impulse or thrusts palpable over the precordial area. The chest x-ray and electrocardiogram are normal.

In the great majority of patients, an innocent murmur can be differentiated from organic murmurs. Problems do arise, however, in patients with aortic sclerosis or mild aortic stenosis. In these conditions, the murmur is generally best heard at the aortic area in the second right inter-

space. Innocent murmurs are generally not well heard over the aortic area.

In summary, the innocent systolic murmur is short and soft, buzzing or higher pitched, best heard at the pulmonary area or left sternal border, and confined to these areas without radiation to the apex or the neck. It is not increased by Valsalva maneuver, although exercise may alter the intensity. The first and second heart sounds are normal; ejection sounds and pathologic gallops are absent; and the ECG and chest x-ray are normal.

Holosystolic Murmurs

A holosystolic murmur is not innocent, occurring with mitral regurgitation, tricuspid regurgitation, or ventricular septal defect. Holosystolic murmurs begin with the first heart sound and envelop aortic valve closure. Their intensity ranges from grade 2 to 5, the louder murmurs being associated with a systolic thrill. In patients with mitral regurgitation, the holosystolic murmur is heard well at the apex and is well transmitted into the left axilla. When mitral regurgitation is due to a flail leaflet and ruptured chordae to the posterior leaflet, the murmur may be transmitted into the base of the heart to the aortic area. A flail mitral leaflet with severe mitral regurgitation may occur from bacterial endocarditis, spontaneous rupture of the chordae in chronic rheumatic heart disease, with the mitral prolapse syndrome, and during acute myocardial infarction.

In patients with tricuspid regurgitation the holosystolic murmur is heard best along the lower left sternal border at the tricuspid area; the murmur may increase with inspiration in response to the increased venous return and a large V-wave may be noted in the neck veins. This impulse in the jugular veins occurs after the first heart sound and is due to tricuspid regurgitation. In patients with a simple uncomplicated ventricular septal defect, the left ventricular systolic pressure is higher than the right ventricular pressure throughout systole so that the murmur is holosystolic. Progressive pulmonary hypertension changes the timing of this holosystolic murmur. In patients with severe pulmonary hypertension, flow through the defect is minimal, and the murmur is short and confined to early systole.



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In these patients the auscultatory findings of pulmonic ejection sound, loud pulmonary valve closure, and the murmur of pulmonary regurgitation are conspicuous findings.

An early systolic murmur begins with the first heart sound, diminishes in a decrescendo fashion, and ends in midsystole. It may be associated with ventricular septal defect, mitral or tricuspid regurgitation.

With spontaneous closure of a ventricular defect the murmur may disappear. The early murmur represents flow during early systole; during ventricular contraction the defect is closed and the murmur is not heard. The early systolic murmur is also a feature of severe tricuspid or mitral regurgitation. Severe regurgitation is confined to early systole.

Late systolic murmurs occur in patients with mitral regurgitation owing to a floppy mitral valve. In patients with mitral prolapse, the murmur begins in midsystole and ends with the second sound. Mitral regurgitation is confined to

late systole because of late systolic regurgitation. The precordial honk or whoop is an easily recognized, unique, loud, sonorous sound, usually confined to late systole. It is generally associated with mitral valve leaflet prolapse and mitral regurgitation.

Extra cardiac systolic murmurs may originate in arteries because of tortuosity or luminal narrowing or to increased flow through a normal vessel. These murmurs are heard in patients with coarctation of the aorta or pulmonary branch stenosis.

Innocent supraclavicular systolic arterial murmurs can be heard in normal children and adolescents. Innocent murmurs are short, often louder than grade 2, and probably originate in the neck vessels. These murmurs are generally poorly transmitted over the precordial area so that differentiation from aortic stenosis and pulmonary stenosis is not difficult. They can be made to decrease by hyperextending the shoulders.

DIASTOLIC MURMURS

Diastolic murmurs are considered organic. The early diastolic murmur of aortic regurgitation is well transmitted along the left sternal border and also to the apex. When aortic regurgitation is caused by syphilis, dissecting aneurysm of the aorta, aneurysm of the sinus of Valsalva, traumatic aneurysm of the aorta, aortitis, bacterial endocarditis, or the Marfan's Syndrome, the diastolic murmur may be heard best along the right parasternal border particularly at the third and fourth right interspace. The left ventricle is frequently hyperkinetic, and the carotid pulse is consistent with high pulse pressure and a rapid upstroke. The early diastolic murmur of pulmonary regurgitation from pulmonary hypertension is rare. The Graham Steell's murmur of pulmonary regurgitation is generally confined to the pulmonary area.

Mid-Diastolic Murmurs

The rumbling mid-diastolic murmur of mitral stenosis is best heard at the site of left ventricular impulse with the bell of the stethoscope. The longer the diastolic murmur of mitral stenosis, the more severe the obstruction. The diastolic

lurmur begins with the loud opening snap and continues to the loud first heart sound. Presystolic accentuation of the diastolic murmur is noted in patients with normal sinus rhythm. In the rare condition of tricuspid stenosis, a diastolic murmur is best heard along the lower left sternal border and increases in loudness during inspiration.

In conditions that produce increased flow, mid-diastolic murmurs may be generated across the mitral or tricuspid valve. These murmurs are typically short and are generally heard in mid-diastole. Late diastolic or presystolic murmurs occur with atrial contraction. They may be heard in patients with mitral or tricuspid stenosis and also in patients with myxoma of left or right atrium.

Continuous murmurs occur because blood flow from a higher to a lower pressure area continues without interruption from systole into diastole. These murmurs are usually due to organic cardiovascular problems, such as patent ductus arteriosus, congenital or acquired arterio-venous fistula,

and sinus of Valsalva perforation into the right heart. Continuous murmurs may also be heard in constricted vessels such as coarctation of the aorta, pulmonary branch stenosis, pulmonary embolism, and carotid artery obstruction.

The "mammary souffle" is an innocent continuous murmur heard during late pregnancy and early postpartum. This innocent and benign venous hum is an example of a continuous murmur due to altered flow patterns in veins. The hum is best heard with the patient examined in the sitting position. It may be louder in diastole and can be abolished by simple digital compression of the internal jugular vein on the same side. Transmission of a loud benign venous hum to the areas below the clavicles may be mistaken as patent ductus arteriosus. It is important for the physician to apply direct pressure to the jugular vein which obliterates the hum and the transmitted murmur over the upper precordium.

ADDITIONAL READING

Hurst JW: The Heart, third edition. Boston, McGraw Hill Pub Co, 1974.

An editorial version of material used by Drs. Segal, Kotler, and Likoff with their patients appears on the next page; photocopy for your patients is permitted.

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HEART MURMURS

Information for Patients

What is a murmur?

A murmur is a noise or a continuous sound that is heard with the stethoscope over the chest.

Are all murmurs due to heart disease?

No; the great majority of murmurs are perfectly innocent (synonym, functional). About 10 to 15% of all preschool and school children have murmurs. In about 98% of these children the murmurs are perfectly innocent and there is no evidence for underlying heart disease. These murmurs tend to disappear as the child grows older, suggesting that the innocent murmur is due to increased speed of blood flow in a normal heart or through the aortic and pulmonary valves, particularly in thin-chested children.

Should the patient with a murmur be referred to the cardiologist?

In the great majority of patients further consultation is not needed. When the murmur is loud, however, and there is a suggestion of organic heart disease, further studies are necessary. An electrocardiogram, a chest x-ray, should be done to exclude any associated abnormality.

When is echocardiography performed?

In recent years the echocardiogram has become valuable in diagnosing atrial septal defects, hypertrophy of the septum, mitral stenosis, and many other conditions.

When should heart catheterization be performed in patients with heart murmurs?

When the physician concludes that organic heart disease is present and when it is necessary to document precisely the degree of obstruction or incompetence (leak) across the valve or define a problem within the heart, heart catheterization may be necessary. The patient is wide awake

during the procedure at which time a small spaghetti-like tube is placed in the arm and advanced into the heart. Pressure measurements are then made to determine whether obstruction is present across the valves. Examination of blood removed through the catheter helps determine if a hole in the heart is present. Dye can be injected through the catheter so movie pictures can be taken to determine precisely the degree of obstruction or incompetence (leak) of a valve, the size and motion of the heart chambers. Heart catheterization is performed when organic heart disease is suspected in order to prove the diagnosis and to determine if heart surgery is needed.

What about prophylactic antibiotics for patients with heart murmurs?

Prophylactic antibiotics appear worthwhile in patients undergoing dental manipulation such as extractions or even dental drilling, and for patients undergoing urinary tract instrumentation. Whether patients with valvular or congenital heart disease who undergo abdominal surgical procedures should routinely receive prophylactic antibiotics is still uncertain; however, bacteria which get into the bloodstream can infect these valves, causing a condition called endocarditis.

How often should the patient with a heart murmur be examined?

Your physician should determine the frequency of visits to the office. The patient with an innocent murmur should be occasionally examined, sometimes as often as once a year. The patient with serious heart disease should be examined at more frequent intervals to detect significant changes of progressive problems. In this way, your physician will be able to detect changes early, to make decisions concerning what other tests and what medications are indicated.

THE RESULTS OF DIET THERAPY VS INSULIN IN THE MANAGEMENT OF OBESE DIABETICS

LEWIS B. FLINN, M.D., M.A.C.P.

The most important essential in the management of a diabetic patient is proper follow-up. In the care of most private patients and especially in the care of clinical patients, the most glaring fault is the infrequency of contact with the patient. At the Diabetic Clinic at the Grady Hospital in Atlanta when patients were seen by house officers, patients rarely saw the same physician more than two or three times and often at two-to three-month intervals.¹ A similar situation occurs in many hospitals including the Wilmington Medical Center. Although at the Wilmington Medical Center residents usually do follow patients over a longer period, it is frequently at too long intervals, and ten minutes per patient is about the average for the physician time spent with the patient in the clinic.

In Atlanta all of this has been corrected by dividing the six thousand or more patients who are currently being followed among eight or ten nurse clinicians, each of whom has a file of about 600 patients who are seen from once or twice weekly to once or twice a month, as required. The nurse clinician and/or the dietitian spends thirty minutes with each and every patient. There is a physician (diabetologist) available at all times as back-up for the nurses and the dietitians. A fulltime podiatrist is in the clinic. Clinic equipment includes a Beckman glucose analyzer, which completes specimen analysis in about ten minutes.

The Atlanta program has been monitored for several years during which it has been found most successful in treating more patients more effectively and at a lower overall cost to the hospital. Eighty-five percent of their patients are treated by diet only; only fifteen percent take

insulin, at an estimated saving of \$10,000 a year to the hospital by using less insulin. Hypoglycemic agents were totally removed from the formulary, a saving of \$70,000 annually. The incidence of severe diabetic ketoacidosis has been reduced by 70%, from 500 to 137 patients per year. Diabetes-related amputations have been reduced by 40%, from 144 to 88 per year. Eighty percent of obese diabetics have lost twenty pounds or more. The medical house officers attend the clinic one-half day a week as part of their education program.

At the meeting of the American Diabetes Association in St. Louis in June, 1977, Dr. Davidson reported a group of 35 obese patients from this same clinic in whom there was a marked reduction in hyperglycemia and glycosuria with abrupt stoppage of insulin along with restricted diet.

In the Diabetic Clinic at the Wilmington Medical Center, an effort has been made recently to follow in general the guidelines used by Dr. Davidson in his clinic. So far, the paucity of personnel has limited the number of very obese patients who could be followed in the detailed manner described. Approximately 20 patients have been closely followed by a part-time nurse, two part-time dietitians, a part-time volunteer, and myself. Part-time social service workers have also assisted. We have at least been able to demonstrate that the concepts outlined above are also applicable elsewhere, given sufficient personnel. We have already monitored a \$1500-to-\$2000-a-year saving to the hospital by curtailing the prescription of hypoglycemic agents in the clinic. Insulin is also being used considerably less, but this decrease has not yet been quantitated.

In a number of patients we have been able to stop abruptly the administration of insulin,

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along with a period of starvation then followed by a low caloric diet with considerable success. When insulin is stopped and starvation instituted, the blood sugar usually falls to near normal and glycosuria disappears. Acetonuria occurs as a result of starvation, but there is rarely an increase in plasma acetone. (Should the latter occur, then insulin will be needed.)

Motivation and education of the patient are essential. Frequent contact by clinic visits, telephone, and house visits by social workers are important. Some patients have been fasted as outpatients.

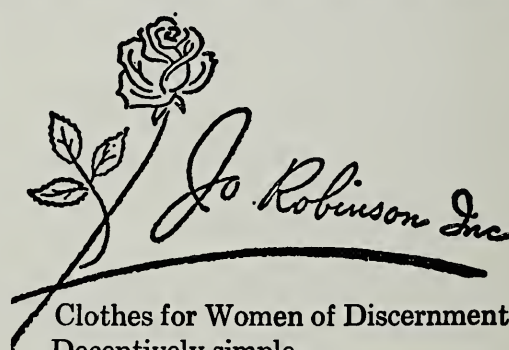
It should be emphasized that periods of starvation and very low caloric diets are not new in the treatment of diabetes. Such regimens were the mainstay of treatment before insulin in the Allen era. Dr. Garfield Duncan and others have advocated similar programs for many years; however, the advent of insulin and especially the introduction of hypoglycemic agents in the 1950's resulted in less and less emphasis on diet.

Evidence is currently developing to indicate that insulin may encourage smooth muscle proliferation in arteries with resultant impairment in circulation, may increase level of plasma triglycerides and perhaps precipitate immunological complications,²⁻⁵ all of which suggest that insulin should be used as sparingly as possible. Obese diabetic patients have less hyperglycemia, lower plasma insulin, and less glycosuria on a low caloric diet without insulin than when insulin is administered.

It has recently been well demonstrated that in the target cells of the obese the concentration of insulin receptors which are reduced in hyperinsulinemia is markedly increased by fasting accompanied by a fall in serum insulin.⁶ This has been particularly stressed by Jesse Roth⁷⁻⁹ at Bethesda and Jerrold M. Olefsky¹⁰ at Stanford University. It has also been pointed out by Winick that in man there are two general types of obesity: the hyperplastic, occurring usually in early childhood, in which there are too many fat cells, and the hypertrophic variety in which the fat cells are too large.¹¹ Although there is considerable overlap, the latter type is more prevalent in adults. The early onset, or hyperplastic type, is more difficult to control.

Recently, there has been some interest in putting patients on a semi-starvation regimen withdrawing all foods for one, two, or three months, but giving amino acid concentrates. This seems to be quite safe if the patients are closely followed. The theory is that some very obese patients prefer to take medicine, that is, amino acids or protein concentrates and no recognizable food, instead of being subjected to severe food restrictions and eating of small, specified amounts. Genuth and Vertes have had about 60% success in Cleveland using a 300 calorie daily diet of casein and glucose which is considered by the patients as medicine and not food.¹²

Blackburn in Boston found fasting supplemented by liquid protein in selected obese individuals resulted in considerable weight loss without serious side effects when the patients were kept under close observation.¹³ *Reaccumulation of weight* when a balanced diet was resumed (as is observed after total starvation) did not occur. Numerous varieties of amino acid concoctions are being exploited throughout the



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country, many of them probably inadequately controlled.

There have been perhaps 15 instances of sudden death reported in patients taking so-called liquid protein over long periods, some of them closely followed by physicians. A detailed case report in *The New England Journal of Medicine* suggests that prolongation of the QT interval in the EKG may be the most important objective finding, suggesting that hypocalcemia or hypomagnesemia may be the critical factor.¹⁴ Attention was called to sudden death in many instances in famine areas throughout the world and in the Warsaw Ghetto. Heart muscle fiber deterioration and irreversible ventricular tachycardia may be the cause of death. Dr. Philip Felig discussed this problem of low calorie liquid protein intake in an editorial in the same issue of *The New England Journal of Medicine*.¹⁵ His conclusion recommends that such diets be conducted only under careful metabolic research supervision. He suggests that some added carbohydrates may prevent catastrophe. Perhaps it is for this same reason that Genuth and Vertes in their large experience had no catastrophes since they administered glucose along with casein, the milk protein which contains all the essential amino acids.

In the Diabetic Clinic at the Wilmington Medical Center, we have given a few patients calcium caseinate (*Casec*—Mead Johnson & Company), flavored according to taste, with one of the flavors ordinarily dispensed with *Ensure* (Ross Laboratories). Two tablespoons of *Casec* in water four times a day provide 150 calories. Some weight loss occurred, but none of our patients have remained on this regimen long enough to result in great weight loss. None have shown any deleterious effect such as has been described above.

Our policy at present in the few cases receiving *Casec* is to give six to eight tablespoons of *Casec*, representing 20-30 grams or about 140 calories for one to two weeks and then, if tolerated, to add carbohydrate in the form of *Poly-cose* (Ross Laboratories) 30 grams/day, approximating 130 calories. *Poly-cose* is more palatable than glucose. After four or five weeks the patient is given an isocaloric general diet.

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The majority of the clinic patients are female, black, and overweight in keeping with the urban population it serves. This also is in keeping with diabetic clinics in other urban centers. Obesity is more common in women and in the poor and relatively uneducated. Why this occurs is not clear, although there are many theories.

Many markedly obese patients have been followed in our clinic for three years, all taking large doses of insulin, all supposedly following a prescribed diet, but still hyperglycemic, glycosuric, and obese. (Table 1) A few have been followed without any reduction in weight, but with the blood sugar approaching normal. (Table 2)

A number of patients were followed more closely in a special clinic where their diets were carefully monitored and their insulin reduced and then discontinued. The encouraging results in this group are illustrated in Table 3. All of the patients feel well, better than when taking insulin, and have less glycosuria and lower blood sugar levels.

Illustrative Cases

Case No. 1 B.W.

For four years this patient took 50 units of insulin in addition to DBI, and supposedly followed a 1200 calorie diet, but she continued to run high blood sugars. With diet control, she lost some weight, but blood sugars were still above 300. With further reduction in calories and discontinuation of insulin, she lost 60 pounds, felt well. Her blood sugar became lower but still remains above normal.

Case No. 2 A.S.

From 1972 to 1974, this patient's blood sugar was high. She weighed 250 pounds, and was taking 60 units of insulin daily. With a low calorie diet, her weight gradually declined to 235 pounds; her blood sugar became near normal without any insulin.

Case No. 3 E.K.

From 1975 to 1977, her weight was 245 pounds, her insulin dose 10 to 15 units, and her blood sugar ranged from 240 to 300. From 1976 to

TABLE 1
OBESE DIABETIC PATIENTS FOLLOWED FOR THREE YEARS OR MORE
TAKING INSULIN IN LARGE DOSAGE, WITHOUT WEIGHT
LOSS AND WITHOUT REDUCTION IN BLOOD SUGAR

	HT.	WT.	1975 B.S.	INS.	WT.	1976 B.S.	INS.	WT.	1977 B.S.	INS.
J.B.	67	237	192	40	212	280	40	226	347	40
G.C.	62				210	338	65	203	315	65
M.C.	61	184	372	45	180	310	45	181	300	60
I.C.	61	192	300	80	182	377	80	177	300	80
N.C.	63				272	302	30	276	4+	30
M.L.C.	61	194	309	60	185	284	40	182	4+	45
B.C.	62	244	226	35	226	502	35	230	440	35
S.D.	60	178	165	45	180	228	45	178	2+	45
T.E.	62 1/4	210	396	40	214	222	40	222	432	45
M.F.	65 1/2	177	396	58	177	236	58	180	4+	58
A.G.	73	228	193	55	225	291	55	227	125	55
A.G.	70	291	361	50	290	4+	50	281	334	50
E.G.	61 3/4				187	305	35	187	444	35
S.G.	61	212	244	70	200	271	70			
E.H.	67	207	145	45	198	580	30	189	210	30
M.J.	61 1/2	220	186	40	222	190	40	198	399	40
W.L.	66	234	376	60	227	0	75	231	3+	75
J.M.	64 3/4				221	351	20	208	370	50
E.M.	59		270		214	230	45	207	1+	45
G.M.	65 1/2				186	446	40	193	486	40
J.M.	65 1/2	182	414	60	185	313	90	183	2+	90
L.M.	62 1/2	164	484	65	166	257	70	174	315	70
C.N.	63	191	313	40	185	400	50	205	200	50
E.R.	57	203	261	60	200	4+	70	194	250	70
J.R.	56	203	195	30	204	239	25	198	N	25
C.R.	61	238	311	25	246	309	25			
I.R.	61 1/2	213	370	60	221	389	60	210	4+	60
S.S.	64	237	381	50	230	385	50	241	355	50
D.S.	68				332	309	48	353	380	48
A.S.	64	220	374	45	213	351	45	204	395	45
J.W.	61	227	213	85	215	221	90	213	272	90
E.W.	61 1/2	202	320	35	205	305	35	205	200	35
C.W.	62 1/2				205	237	35	202	4+	35
M.B.	62	199	282	65						
W.M.R.	63 1/2	191	271	35	222	3+	50	210	522	30
J.R.	56	200	241	30	204	239	25	198	N	20

TABLE 2

DIABETIC PATIENTS FOLLOWED AT LEAST THREE YEARS WITH REDUCTION
IN BLOOD SUGAR WITH CONTINUED HIGH DOSAGE
OF INSULIN BUT WITHOUT WEIGHT LOSS

	HT.	WT.	1975 B.S.	INS.	WT.	1976 B.S.	INS.	WT.	1977 B.S.	INS.
O.A.	66	242	266	60	249	222	60	240	165	60
M.B.	62	199	280	65	195	225	60	196	202	60
N.B.	61	197	162	35	188	165	35			
B.	64	234	205	80	208	216	80	227	191	30
P.C.		250	206	60	196	92	25		*	
J.C.	62	239	336	30	236	175	40	227		54
S.C.	67	202	167	75	204	286	55	194	103	70
L.M.F.	65	201	273	60	205	*	60	202	**	60

*urine negative

**urine 4+

1977, with her diet controlled at 800 to 1000 calories, her weight dropped to 230 pounds, and blood sugar ranged from 230 to 240 with no insulin.

Case No. 4 C.P.

In 1976, this patient was taking chlorpropamide. She weighed 225 pounds; her blood sugar was 360. With a low calorie diet, no oral diabetic agent and no insulin, her weight dropped to 190, and her blood sugar to 190.

Case No. 5 H.S.

In 1975, she weighed 200 pounds; her blood sugar was 550, her daily insulin 20 units. In 1976, she weighed 215 pounds, and her blood sugar was 400, despite daily insulin of 95 units. After insulin was discontinued, her weight de-

creased to 188, her blood sugar to 170, and she felt well. No acetonuria was present. Before insulin was discontinued, this patient was admitted to the hospital on two occasions during which her blood sugar was examined every six hours without revealing any additional useful information. Each time, she was discharged to take 80 units of insulin.

Case No. 6 M.B.

From 1968 to 1973, her weight was 230 to 250 pounds. Because of bothersome pruritus, hypoglycemic agents were administered. Her blood sugar was 200 to 375 mg. In 1974, insulin was started which resulted in relief of the pruritus, but her weight remained at 250 pounds, her blood sugar at 210 to 230. In 1976, insulin was discontinued. Her weight then dropped to 200,

TABLE 3

ILLUSTRATIVE CASES, WHEN INSULIN WAS ABRUPTLY STOPPED, OF THE
CLINICAL COURSE OF MARKEDLY OBESE AND
HYPERGLYCEMIC DIABETES

	HT.	WT.	1975 B.S.	INS.	WT.	1976 B.S.	INS.	WT.	1977 B.S.	INS.
B.W.	63	256	240	70	245	290	50	200	270	0
A.S.	63 ½	260	148	60	245	129	60	235	100	0
E.K.	62 ½	245	356	25	250	208	15	238	162	0
C.P.	62 ½				230	300	None*	193	190	0
H.S.	65 ½	198	432	50	210	493	70	188	130	0
M.B.	65	243	287	75	241	330	75	202	221	0
E.B.	62 ½	187	284	65	195	300	90	161	270	0

*Chlorpropamide

her blood sugar to 220, and the patient felt very well.

Case No. 7 E.B.

In 1968 to 1971 she weighed 180 pounds. Hypoglycemic agents were prescribed; blood sugar varied from 120 to 300. In 1972, insulin was started and increased to 90 units, at which time she weighed 195 pounds and her blood sugar was 250 to 300. In 1977, when insulin was discontinued, her weight dropped to 165, her blood sugar was 270, and she felt very well.

Conclusion

The mainstay of good diabetic management is diet tailored to the need of the individual patient. Hypoglycemic agents should be used rarely, if at all, in the treatment of diabetics, and certainly not if they are above ideal body weight. In mature onset diabetes, insulin should rarely be used until the ideal body weight is reached or approached except during pregnancy, acute infections, or some other special complications.¹⁶ In general, about 15% of mature onset diabetics require insulin; 85%, diet only.

Whether or not they lose weight, many obese diabetic patients have less hyperglycemia and less glycosuria on a low calorie diet without insulin than when taking insulin. If the diet is sufficiently restricted, they will lose weight if given proper follow-up supervision.

Active vigorous daily exercise such as fast walking, stair climbing, bicycling, jogging, etc. should be encouraged, the desirable amount being determined for the individual patient.

Even when weight is properly controlled, frequent follow-up contacts are essential to encourage the patient to adhere to whatever change in life style has been found necessary to maintain proper weight and enjoy the best possible diabetic control.

REFERENCES

1. Personal Communication from Dr. John K. Davidson, Professor of Medicine, Emory University and Director, Diabetic Clinic of Grady Hospital.
2. Little JA, Lee R, Sebrakova, et al: Insulin antibodies and clinical complications in diabetics treated for five years with lente or sulfated insulin. *J Am Diabetes Assoc* 26:980-988, 1977.
3. Faulk WP, Tomsovic EJ, Fudenberg HH: Insulin resistance in juvenile diabetes mellitus. *Am J Med* 49:133-139, 1970.
4. Faulk WP, Karam JH, Fudenberg HH: Human anti-insulin antibodies. *J Immunol* 106:1112-1116, 1971.
5. Maloney PJ, Aprile MA, Wilson S: Sulfated insulin for the treatment of insulin-resistant diabetics. *J New Drugs* 4:258-263, 1964.
6. Kolata GB: Hormone receptors: how are they regulated? *Science* 196:747-800, 1977.
7. Bar RS, Roth J: Insulin receptor states in disease states of man. *Archives Int Med* 137:474-481, 1977.
8. Archer JA, Gordon P, Roth J: Defect in insulin binding to receptor in obese man. *J Clin Inv* 55:166-174, 1975.
9. Bar RS, Gordon P, Roth J, et al: Receptors in circulating monocytes of obese patients. *J Clin Inv* 58:1123-1135, 1976.
10. Olefsky JM: Decreased insulin binding to adipocytes and circulating monocytes from obese subjects. *J Clin Inv* 57:1165-1172, 1976.
11. Winick M: Childhood Obesity. *Nutrition Today* 9:6-12, 1974.
12. Genuth SM, Castro JH, Vertes V: Weight reduction in obesity by outpatient semi-starvation. *JAMA* 230:987-991.
13. Blackburn G, Bistrian B, Flatt JP: Preservation of the physiological responses in a protein sparing modified fast. *Clin Research* 22, 1974.
14. Michiel RR, Sneider JS, Dickstein RA, et al: Sudden death in a patient on a liquid protein diet. *NEJM* 298:1005-1007, 1978.
15. Felig P: Four questions about protein diets. *NEJM* 298:1025-1026, 1978.
16. Davidson JK: Controlling diabetes mellitus with diet therapy. *Postgrad Med* 59:114-122, 1976.

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CHONDROSARCOMA OF THE HAND

JOSEPH A. ARMINIO, M.D.
PATRICK F. ASHLEY, M.D.
LEMUEL O. HERRERA, M.D.

Chondrosarcoma, a tumor originating from cartilaginous tissue, is one of the more common tumors occurring in bone. It occurs most frequently in the long tubular bones, especially the femur, and also in certain flat bones: the pelvis, sternum, and ribs.¹ Because chondrosarcoma rarely occurs in the hands,^{2,3} the following case is of interest.

Case Report

The patient is a 73-year-old, right-handed Caucasian farmer who presented in December 1975 to his family doctor with a swelling in his right groin that had progressively increased in size. On physical examination, the doctor found the mass to be a hernia. A mass on the patient's right hand was also noted, whereupon the patient stated that he had experienced discomfort and dull pain for approximately the past seven years during which time the mass on his hand had gradually enlarged. No history of trauma, insertion of foreign body, or of previous deformity was recalled. The mass, which apparently arose from the metacarpal phalangeal joint and the proximal phalanx of the right third digit, occupied the entire dorsum of the hand and produced a marked deformity. (Figure 1 and 2) The mass was associated with an inability to extend fully the second, third, and fourth digits. Both hardness and soft areas were palpable in the mass.

Roentgenological examination revealed an expansile destructive process originating in the third metacarpal and involving its entire length, except for the most distal surface. The tumor had broken through the shaft of the metacarpal

and tumorous new bone was evident in the soft tissue. (Figures 3 and 4) Deformities of the second and fourth metacarpals suggested either invasion or pressure atrophy.

Tissue obtained via incisional biopsy demonstrated a tumor composed of cartilaginous tissue



FIGURES 1 and 2

A mass occupies the entire dorsum of the hand and produces marked deformity.

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Chondrosarcoma of the Hand—Arminio

with a stromal background of pale gray, myxomatous tissue, containing cells of a chondrocytic nature. (Figure 5) There were cells with hyperchromatic nuclei and variations in size and shape, binucleation, and the presence of mitotic figures. (Figure 6) The features were those of a chondrosarcoma.

The patient was admitted to the hospital. Pre-operative studies, including SMA 12, EKG, and chest x-ray showed no abnormalities. On December 12, 1975, amputation of the right hand proximal to the wrist joint was performed. (Figure 7) The patient was discharged on the third post-operative day. A working prosthesis was fitted so that he now has a useful right upper extremity. To date there has been no evidence of recurrence of the tumor.

Discussion

Chondrosarcoma of the hand is a rare tumor. In his review of 349 tumors, Boyes found only one;⁴ after a review of 1499 tumors Posch could not find one case.⁵ Dahlin and Salvador found a total of 17 cases of chondrosarcoma of the hand reported in the world literature and were able to add 14 cases of their own; their report, the largest series published to date, shows a total of only 31 cases.²

Most of these tumors arise "de novo" as primary tumor; however, secondary neoplasms can be found, especially in people with multiple osteocartilaginous exostoses or multiple enchondromatoses.

Clinically it is not uncommon to obtain a history that indicates that the mass has been present for a long period of time, as in this case. A possible explanation, especially in well-differentiated chondrosarcomas is that the doubling time is long, often up to one year.⁶ The most common site of origin is the proximal phalanx. Although swelling and pain are present, neither is a consistent or constant finding. While there seems to be no particular sex difference at the present time, age may be significant: no patient with chondrosarcoma of the hand has been younger than 40 years.

Roentgenographic features of chondrosarcoma vary from a benign appearing osteolytic lesion



FIGURE 3

X-ray disclosing the expansile destructive process originating in the third metacarpal.



FIGURE 4

X-ray disclosing the tumor has broken through the shaft of the metacarpal with new bone evident in the soft tissue.

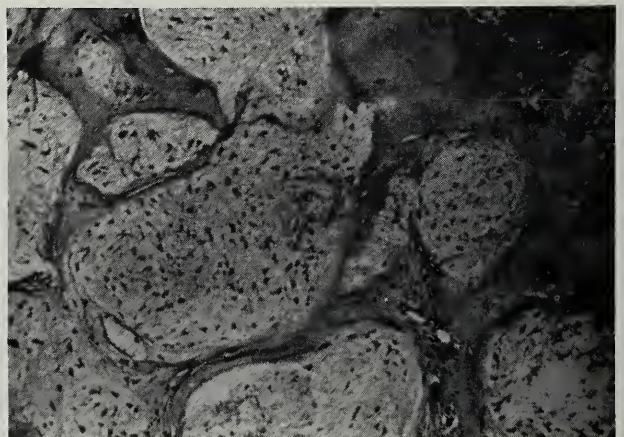


FIGURE 5

Photomicrograph showing tumor composed of cartilaginous tissue with a stromal background of myxomatous tissue (x250).

with sclerotic margins and the frequent presence of small, irregular calcifications to aggressive appearing osteolytic lesions with poorly defined margins containing irregular "snowflake" calcifications. They may become quite large, be expansile, and show a prominent soft tissue component.

Biopsy of the lesion is an essential step. The degree of nuclear atypia, the chromatin pattern, the prominence of nucleoli, and the differentiation and stromal invasion seen with the light or electron microscope are used as criteria in the histological grading of the tumor.⁷ When the definitive treatment is carried out, the biopsy site should be removed with the resection.

Chondrosarcomas of the hand are slow growing tumors of low biological aggressiveness. When metastatic dissemination occurs, it is mainly via the vascular stream. Only three of the patients of Dahlin's series died of pulmonary and disseminated metastases.² These patients had been treated initially by excision. When local recurrences developed, subsequent amputations were performed, but the patients nevertheless succumbed. Had the initial treatment of the patients been by amputation of the hand with a good margin of normal tissue, local control of the tumors might have been successful for cure.

Conclusion

In conclusion, the world literature on the subject shows chondrosarcoma of the hand is a rare

lesion with only 31 cases reported up to the time of this report. The treatment of choice after confirming biopsy is amputation with a wide margin of normal tissue.

Summary

Chondrosarcoma is a tumor which rarely occurs in the hand. It is a slow-growing neoplasm which may be cured by adequate surgical excision.

An example of this tumor is presented in this report and the pertinent literature reviewed. At the time of this publication, the patient has survived 29 months following what it is hoped will have been curative surgery.

ADDENDUM

Two excellent additional papers on chondrosarcoma of the hand have been published while this paper was in press. These papers summarize the treatment of 19 and 11 cases respectively. Their conclusions confirm and emphasize our proposed treatment.

Roberts PH, Price CHG: Chondrosarcoma of the bones of the hand. *J Bone & Joint Surg* 59:213, 1977.

Patel WR, Pearlman HS, Engles J, Dollomide BS: Chondrosarcoma of the proximal phalanx of the finger. *J Bone & Joint Surg* 59:401, 1977.

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REFERENCES

1. Spout JH: Cartilaginous malignant tumors arising in the skeleton. Seventh National Cancer Conference Proceedings, pp 922-925.
2. Dahlin RA, Salvador AH: Chondrosarcomas of the hands and feet. *Cancer* 34: 755-760, 1974.
3. Lewis MM, Marcove RC, Bullogh PA: Chondrosarcoma of the foot. *Cancer* 36:587-590, 1975.
4. Boyes JH: *Bunell's Surgery of the Hand*, p 666. Philadelphia, JP Lippincott, 1970.
5. Posch JL: *Hand Surgery*, p 644. Baltimore, Williams and Wilkins, 1975.
6. Spratt JS: The rates of growth of the skeletal sarcomas. *Cancer* 18:14-20, 1965.

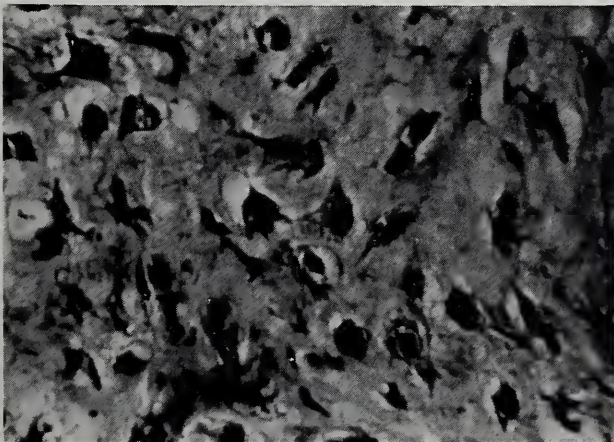


FIGURE 6

Biopsy specimen showing cells of chondrocytic nature with hyperchromatic nuclei, pleomorphism, binucleation and mitotic figures (x800).



FIGURE 7

Sagittal section through mid-portion of the tumor in the amputated hand.

FINANCIAL INFORMATION PHYSICIANS SHOULD HAVE, PART II

LEIF C. BECK, LL.B., CPBC
VASILIOS J. KALOGREDIS, J.D.

Introduction

Last month we began this two-part series by describing the significance of a weekly report. In addition, the importance of a more management-oriented monthly financial statement was stressed.

This month's article will specifically focus on the relevant financial information a physician and his advisors should have available on a regular and timely basis.

In addition, a sample in-house monthly financial statement is included as part of this article. It will be referred to throughout this article. Its specific categories and format will not be the best for each practice. We believe the basic concepts embodied by the form, however, can and should be applied by each practice so the best in-house financial report can be established for it.

The Relevant Financial Information

1. *Charges (Productivity)*. Charges are a very important management tool. They are not normally provided in practice's accounting statements. Most accounting reports are geared primarily to tax return preparation and therefore ignore the charges, which do not directly affect income taxes in the typical "cash basis" medical practice.

This is a great deficiency in the normal accounting reporting processes. Charges provide the practice with figures to help determine trends within the practice. In addition, charges are necessary in the preparation of the collection ratio and in keeping "a running score" on the accounts receivable of a practice. Both of these aspects will be described later in this article.

Page 2 of the sample monthly financial statement breaks charges down between Hospital No. 1, Hospital No. 2, the main office, and the satellite office. In addition, it breaks down the charges between the two doctors and ancillary personnel producing income. These were the relevant pieces of productivity information in this particular practice.

Other practices may find that the productivity should be broken down into different categories. The important thing is for each practice to decide what charge information it wants and then provide for it.

We are finding more and more group practice physicians dividing their income at least partially on productivity elements, tied to charges. Obviously, in those instances, it is most important that the charges, by doctor, be segregated.

Some physician groups may protest that keeping track of each doctor's production might be divisive. In reality, such information often tends to head off developing differences in a group.

Messrs. Beck and Kalogredis are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd, Pennsylvania.

Financial Information Physicians Should Have—Beck

M. E. SURGICAL ASSOCIATES, LTD.

Monthly Financial Statement for _____, 19__

	This Month	Year-To-Date	Ratios; Comments	Budgeted for Year
<u>TOTAL CHARGES</u> (per page 2)	\$ _____	\$ _____		\$ _____
<u>RECEIPTS:</u>				
Office:	\$ _____	\$ _____		\$ _____
Mail:	_____	_____		_____
<u>TOTAL RECEIPTS</u>	\$ _____	\$ _____		\$ _____
<u>EXPENSES:</u>				
Lay Payroll (Gross)	\$ _____	\$ _____		\$ _____
Payroll Taxes				
Rent				
Professional Supplies				
Professional Insurance				
Office Supplies & Expenses				
Professional Fees				
 TOTAL "OVERHEAD"	 \$ _____	 \$ _____		 \$ _____
 Doctors' Expenses:				
Salaries				
Pension				
Profit Sharing				
Medical Expense Plan				
Insurance				
<u>Total for Doctors</u>	\$ _____	\$ _____		\$ _____
 TOTAL EXPENSES (except depreciation & interest)	 \$ _____	 \$ _____		 \$ _____
 NET INCOME	 \$ _____	 \$ _____		 \$ _____

If one physician is constantly producing less, he and his partners should either openly recognize that he contributes more to the practice in other ways or else they should seriously and openly discuss a change in their income division formula to reflect this. In reality, differences such as these will surface sooner or later. Oftentimes, the later they surface, the more difficult they are to resolve.

Therefore, the parties are better served to have the facts available on a running basis so that they can deal with it currently and openly. Many times the actual figures end up being much closer than the parties might have expected.

2. *Receipts.* Receipts are summarized in all accounting reports; however, we recommend that they be broken down between "office receipts" (meaning moneys received at the time of service) and "mail receipts" (which would include all other receipts). Note that the suggested

monthly financial statement does provide for that.

3. *Collection Ratio.* Most practices have no idea what their legitimate collection ratio is. It is not difficult to compute. Practice receipts are divided by practice net charges (meaning charges reduced by Blue Shield, Medicare, and Medicaid disallowances for which the patient cannot be billed). Note that page 2 of the suggested monthly report has room for the Blue Shield, Medicare, and Medicaid disallowances (for the month and year to date) as well as the collection ratio for the month and year to date. This is very relevant and important information which allows a practice to keep on top of things. National averages show that collection ratios around 93% to 96% are the norm.

4. *Accounts Receivable.* Accounts receivable are not normally provided by accountants in practices' accounting statements. Page 2 of the

Financial Information Physicians Should Have—Beck

sample provides space for listing the accounts receivable figure, as well as the amount written off, in a particular month.

An adding machine tape should be run of all outstanding accounts in order to come up with a starting figure. Once one has that, it is easy to add that month's charges, and subtract that month's receipts and write-offs to come up with a realistic accounts receivable figure. Periodically (at least twice a year) an adding machine tape should be run on the outstanding accounts as a check against the monthly summary total that is being run on the financial statement. If there is a large disparity between the two, there may be a problem.

Many practices have recovered account cards that otherwise may never have been billed. For example, if the monthly summary indicates that accounts receivable should be \$100,000 and an adding machine tape of the outstanding account cards shows that only \$88,000 is outstanding, there is a problem. Either someone has been

embezzling, some cards have been lost or misfiled, or else a very serious mathematical error has occurred.

The possibility of discovering any or all of these very serious errors makes this "accounts receivable balancing" a very important and necessary part of any well-run medical practice.

5. *Expense.* Practice expenses should be summarized. The monthly financial statement sample breaks down the overhead into several categories (many practices will have others) and also segregates the doctors' expenses portion of the overhead for information purposes. That would be the doctors' salaries, retirement plan contributions, medical benefits, insurance benefits, and the like.

This expense information can be easily gathered from a check register which provides columns for the breakdown of expenditures within a practice. One of the beauties of the peg-board checkwriting system is that this can be done under a "write it once" approach, which

Page 2

M. E. SURGICAL ASSOCIATES, LTD.

Supporting Information -- for _____, 19__

	This Month	Year To Date			
CHARGES:			Overhead percentage for month _____%		
Hospital #1	\$	\$	Overhead percentage year to date _____%		
Hospital #2			Accounts Receivable \$ _____		
Main Office			(Written off this month -\$ _____)		
Satellite Office	_____	_____		Month	Year
	\$ _____	\$ _____	Collection Ratio	_____%	_____%
Dr. M.	\$	\$	Blue Shield Disallowances	\$ _____	\$ _____
Dr. E.			Medicare Disallowances	_____	_____
Ancillary			Medicaid Disallowances	_____	_____
Personnel	_____	_____	Major procedures:		
	\$ _____	\$ _____	At Hospital #1	_____	_____
			At Hospital #2	_____	_____
Checking balance at month-end		\$ _____	Minors:		
Savings balance \$ _____			At Hospital #1	_____	_____
Special Savings earmarkings:			At Hospital #2	_____	_____
Large bills due soon:					
			Other Information or Comments:		

avoids much duplication. Much of this work can rather easily be done by one's staff without the necessity of having to have the accountant do all of the "posting." From the check register, it will be easy for the bookkeeper to summarize the expenditures by category on a monthly basis and then place them on the monthly financial report.

6. Overhead Ratio. The practice's overhead ratio is calculated by dividing all of the practice's expenses (excluding doctors' expenses as defined above) by the practice's receipts. Note that on the top righthand corner of page 2 of the sample, there is room for the overhead percentage both for the month and the year to date. Here again, trends can be determined. In addition, these figures are very readily available for comparison purposes with other similar practices.

As members of the Society of Professional Business Consultants (SPBC) we annually receive a census summary of relevant charge, receipt, and expense items by specialty. We find them to be very helpful and reliable for comparison purposes. If a practice is dramatically higher or lower than the norm, an alarm is sounded requiring critical evaluation. Having a financial report that has all of these elements available allows quick and easy comparison.

7. Miscellaneous. There is space on the bottom lefthand corner of the report for the checking account balance and the savings account balance. In addition, if any of the savings funds

are specifically earmarked (for example, retirement plan contributions, malpractice insurance premiums, and the like), they should be so designated. In addition, a list of large bills that would be due should be available on this report.

On the bottom righthand corner of page 2, there is room for special comments from the bookkeeper or office manager. This is useful and does provide room for some important observations (eg, the fact that the lease may be up for negotiation, the malpractice premium will be due in a month, etc.).

In addition, on the first page of the report, notice that everything is broken down for "this month" and for "year to date." In addition, ratios (eg, payroll as a percentage of gross receipts) can be listed. The final column on that page provides room for the "budgeted for the year" figure for each item. This will allow for a regular comparison of the actual to the budget from month to month to see if things are in line with what was anticipated.

We are finding more and more practices preparing a budget and finding it to be most useful.

Conclusion

Every physician must decide what information is most important to him so that he can be kept best informed and so that his advisors will have the tools necessary to assist him in making the best decisions. The common problem of discussing practice matters in a vacuum can and should be avoided.



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Editorials

DO OUR ETHICS NEED CHANGING?

Recently, at the House of Delegates of the American Medical Association a special committee was formed to reconsider the wording of the "Principles of Medical Ethics." A rewording had been formulated and presented to the delegates by the Judicial Council. This Council, perhaps, realized instinctively that it was not good form for a judicial body to create or recreate principles for which it may later have to be the court of appeal for the association's members.

Discussions in the reference committees and on the floor of the House of Delegates suggested that the "Principles of Medical Ethics" need change to satisfy the changes in our laws or in the interpretations of our laws.

"The study of standards of right and wrong" . . . "that part of science and philosophy dealing with moral conduct, duty and judgment" . . . "formal or professional rules of right and wrong" . . . "moral principles by which a person is guided" . . . "The seat of ethics is in our hearts, not in our minds." (Atlantic)—These are quotes on ethics from the World Book Dictionary.

The special committee given the task to consider the rewriting of the "Principles of Medical Ethics" will be chaired by Dr. James Todd of New Jersey. Dr. Todd assured me, on the floor of the House of Delegates, that he would make every effort to have his committee contact, in an orderly fashion, every physician in the American Medical Association, for pro and con reactions to "The Principles of Ethics" since he feels the Ethics are personal principles by which each physician wants to be known and to be judged.

If you think as I do, you will submit wording for "The Principles of Ethics"* to the Medical Society of Delaware for forwarding to the special committee that sets standards of behavior for physicians that our laws can only strive to emulate but never exceed. If you adhere to the philosophy that law sets old standards for behavior, then by all means make sure that a code of judgment is formulated and passed on to the AMA's special committee via the Medical Society of Delaware, consistent with such legal standards.

Since these pages permit editorial comment, I have already stated my conviction that moral standards must be higher than legal standards. Therefore, I am firmly against changing the wording or formulation of our "Principles of Medical Ethics" just to satisfy changing whims of us to stretch beyond ourselves to attain the times wording and philosophy that call for each of us to stretch beyond ourselves to attain the highest goals possible.

R.J.B.

*See *Delaware Medical Journal*, February 1978, pp 110-111 for the present and proposed Principles of Ethics. For a copy call the Medical Society of Delaware at 658-7596.



THE CONTACT LENS CONTROVERSY

Over the last few years, and especially over the last few months, we have seen an interesting turn of events regarding the legitimacy of contact lens technicians in Delaware. For a long time, many Delaware optometrists have been trying to expand their own territory at the ex-

pense of constricting the territory of others. It has never been publicly stated that the root of this encroachment may have been economic. The reason stated was the familiar cry of protection of public welfare. Pushing, shoving, and grabbing sometimes present a very conservative face. It is noteworthy that at no time was the competency of the currently practicing contact lens technicians questioned.

Supreme Court Chief Justice Herrmann finally ruled by the letter of the law. His opinion was that Mr. Kuhwald was indeed doing his thing contrary to existing law. Included in his opinion was a specific commentary on the adequacy of and the need for his technical expertise within the Delaware community. Justice Herrmann suggested that legislative channels be explored to permit Mr. Kuhwald to continue his work.

Within several short weeks, appropriate legis-

lation was introduced and passed permitting Mr. Kuhwald to continue his contact lens work. A few members of the Medical Society offered their support, and a few of those went to Dover in his behalf.

There really is only one factor that helped Mr. Kuhwald reinstate himself in the sometimes whimsical market place of the law. The public wanted him. The calls and letters to legislators were numerous. The support of the public that he had served was swift and strong. Appropriate lobbying maneuvers were made both for and against the issues at hand.

With good fortune, Mr. Kuhwald and his group will continue to fulfill a need for contact lens services in Delaware. With good fortune the expansive nature of others who would erode good medical practices in Delaware will be similarly contained.

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Letters to the Editor

To the Editor:

In preparation for a September 14th meeting of the National Institute of Allergy and Infectious Diseases to consider the feasibility and advisability of making the insect sting kit available to certain trained categories of medical and lay persons, without a specific prescription by a physician, I would be interested in receiving information and comments by the readers of the *Delaware Medical Journal* on the following questions:

1. Have you any knowledge of a fatal reaction to an insect sting or drug or food? If so, I would appreciate as much detail as possible, including information concerning the time interval between contact with the offending agent and death.

2. If you know of such a fatality or fatalities, in your estimation, would an immediate on-the-scene subcutaneous injection of a premeasured dose of epinephrine 1:1000 (0.3 cc to 1.5 for adults; 0.2 to 0.3 cc for children) have afforded a different outcome?

3. Have you any knowledge of adverse effects of subcutaneous injections of epinephrine 1:1000 in the above dosages? If so, again I would appreciate as much detail as possible.

We would certainly appreciate any information you can supply.

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Book Reviews

MENTAL ILLNESS AND PSYCHOTROPIC DRUGS
A Program of Stepdesign, Inc. Jonathan O. Cole,
M.D., Chief Medical Consultant, Research Media,
Inc., Cambridge, Massachusetts, 1975. Price
\$30.00. Paperback.

The two-part self-instructional books are a general introduction into the area of mental illness and its drug therapy, using case studies and programmed learning.

"Edna feels as if she is on a boat in a heavy swell and can't get used to the motion. Something is always bothering her or upsetting her . . ." Which word best describes the feelings experienced by Edna: dysphoria, grandiosity, demoralization, or euphoria? By such means does Book I, *Mental Illness*, serve as a textbook designed to allow all "health care professionals and their support teams," including such people as pharmaceutical sales representatives, pharmacists, medical students, nurses, and community health teams "to acquire a thorough knowledge of psychiatric concepts and terminology." Book I seems to me a good way to do this because of its format of questions with their answers on the same page, allowing the student to check his/her comprehension by uncovering the answers as s/he goes along, at his/her own speed.

In Book II, a drug from each major class of psychotropic agents is reviewed. Areas covered include indications, common adverse reactions, allergies, contraindications, and some differences between other drugs in the same class. Dosages of specific agents are not, however, presented. This section is fairly good for those who have not been exposed to the drugs before, but contains several controversial statements, seemingly as fact. For example, the use of amphetamines in pure fatigue is advocated, and the statements are made that there is a distinct difference between flurazepam and other benzodiazepins used as anti-anxiety agents and that there is a difference in the onset of action between the less sedating and more sedating anti-depressants. These concepts are not well supported in the literature. The statement on the use of fixed

ratio combination products and the use of multiple agents is not clear.

THOMAS F. EGAN, *Pharm. D. Candidate*
Philadelphia College of Pharmacy
BERNADINE Z. PAULSHOCK, M.D.

✻ ✻ ✻

COMBINED TEXTBOOK OF OBSTETRICS AND GYNAECOLOGY, 9th ed., edited by **James Walker, Ian MacGillivray, and Malcolm C. MacNaughton**, Longman, Inc., New York, 1976. 877 pp. Illus. Price \$75.00.

The first edition of this distinguished British textbook was edited by the legendary professor, J. M. Monroe Kerr. It was his intent in its initial publication to provide a reference for the undergraduate medical student and the general practitioner interested in obstetrics and gynaecology. The original publication and subsequent editions reflect the experience of the staff in Glasgow, Scotland, where a large variety of serious complications of pregnancy and an extensive gynaecologic service exist. Unfortunately, this monumental Scottish work misses its mark for a similiar American audience.

The style is unmistakably British—formal and, at times, verbose. I found my interest quickly waning as I arduously plowed through detail which, unfortunately, obscures major concepts.

The philosophy of practice in Scotland differs markedly from the approach in the United States in many clinical situations. For example, in obstetrics, the poly-pharmacy approach to the toxemic patient that has been decried in this country in the past several years is still practiced in Scotland. With the outstanding results obtained with the use of magnesium sulfate in the toxemic patient and its wide margin of safety, it is difficult to understand why this is not accepted by our colleagues in Scotland. Concepts of external version and vaginal delivery following cesarean section are not commonly practiced in the United States. The lengthy description of the techniques of the use of destructive instruments has also become archaic. Because of improvement in anes-

thetia and surgical technique for cesarean section, this would offer a safer approach than the use of destructive instruments in the classical situations where destructive instruments were once used. Similar discrepancies also exist in the gynaecologic practice in Scotland, as compared to the state of the art in the United States.

The differences in practice between the two countries were not elicited to condemn practices in Glasgow. Certainly the results of treatment and protocols in Scotland should be studied by the practicing obstetrician and gynaecologist in the United States and the results of this data carefully examined and compared to results in our country. However, for the medical student or the family practitioner interested in obstetrics and gynaecology, this textbook would not meet his needs as it does not reflect the standards of practice in this country.

The cost of this textbook is exorbitant at \$75.00. The medical student and family practitioner in the United States would do better to review one of the standard combined textbooks in our country, such as those by Wilson (\$24.50), or Danforth (\$42.50), or Combine Williams' *Textbook of Obstetrics* (\$35.50), with either Kistner's *Textbook of Gynecology*, (\$27.95), or Novack's *Textbook of Gynecology* (\$29.95), and have the most up-to-date standards of practice in this country, for less money, and in a more readable form.

JEFFRY I. KOMINS, M.D.

✻ ✻ ✻

THE MERCK MANUAL, 13th ed., edited by Robert Berkow, M.D., Merck & Company, Inc., Rahway, New Jersey, 1977. 2,165 pp. Illus. Price \$9.75.

This book is easily transported, attempts to be encyclopedic in coverage, and is most directed towards the general internist, the family physician, and allied medical personnel. Each chapter is thumb-indexed. The price is very reasonable, and at first glance the book appears to have a vast amount of information. There are chapters on all the major medical sub-specialties as well as genitourinary, gynecology, pediatrics, psychiatry, dermatology, ear, nose, and throat, dental, sex, prescription, poison, reference, and a large

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extensively cross-referenced index. The book contains little physiology and few illustrations.

The best chapter in this text (and the first chapter) is the chapter on infectious diseases. This is well written, up-to-date, and an excellent source for information on the epidemiology, clinical course, diagnostic criteria, prophylaxis, and treatment of many diseases. This chapter incorporates the latest antibiotic recommendations (and now resistance patterns) as well as the many serological tests utilized in searching for infection in the immunosuppressed host.

Unfortunately, the remainder of the book is much less useful than the first chapter. Much of the information is not up-to-date, and most of the information can be found elsewhere in more detail.

In conclusion, this book is probably most useful for allied medical personnel (non-physicians) who desire an inexpensive and comprehensive treatise. The first chapter is recommended to all physicians both for reference and as an excellent review of the latest developments in this field.

Book Reviews

1977 YEAR BOOK OF ENDOCRINOLOGY edited by Theodore B. Schwartz, M.D. and Will G. Ryan, M.D., Year Book Medical Publishers, Chicago, 1977. 392 pp. Illus. Price \$22.00.

The key articles of the year, especially those from the international literature, have been summarized in this book. Additional articles of importance are listed at the end of each chapter. After each article the editor explains its significance; occasional articles receive harsh criticisms. Some of the editorial comments are quite humorous.

Some of the newer endocrine topics presented include: galactorrhea, hyperprolactinemia, and pituitary tumors; the changing treatment of acromegaly; bromocryptine in the treatment of acromegaly and secondary amenorrhea; calcitonin and other agents for the treatment of Paget's Disease; palpation-induced thyroiditis; radioiodine for the treatment of all hyperthyroidism; hemoglobin A1c in diabetes and its correlation with control of diabetes; the use of cyproheptadine in the treatment of Cushing's Syndrome;

and whether or not to treat asymptomatic enlargement of the sella turcica.

The summaries are well written. This book is recommended to all medical libraries and all endocrinologists.

HOWARD LEIBOWITZ, M.D.

❖ ❖ ❖

GROWTH AND ITS DISORDERS by David W. Smith, M.D., W. B. Saunders Company, Philadelphia, 1977. 155 pp. Illus. Price \$13.50.

This volume, the 15th in the series, *Major Problems in Clinical Pediatrics*, is dedicated, as per convention, to the wife and kids, but also to "those who recognize that all men are not created equal."

Did you know that "degrowth" of the vertebrae (a word I never saw before nor is it in Random House or Webster's Collegiate dictionaries) begins about 45 years of age but the ear lobes may continue to lengthen into the 80's?

This is a useful reference for anyone who sees children or adults as patients.

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ENDOCRINE AND GENETIC DISEASES OF CHILDHOOD AND ADOLESCENCE by Lytt I. Gardner, M.D., W. B. Saunders Company, Philadelphia, 1975. 1404 pp. Illus. Price \$62.50.

This 1400-page reference book was written by an astonishing number of international experts. It always seems an editorial feat to me that publisher and editor, no matter how gifted, can have coordinated chapters written by 74 different authors.

I particularly like the chapter by James Tanner, which is a synopsis of his own fundamental publications defining growth at adolescence. Gardner's chapter on Historical Notes on Cretinism is a scholarly delight, ranging from Paracelsus to Osler in whose time it first became unanimous opinion that cretinism is caused by thyroid hormone deficiency.

This costly but necessary book should be accessible to anyone who sees non-adult patients.

BERNADINE Z. PAULSHOCK, M.D.

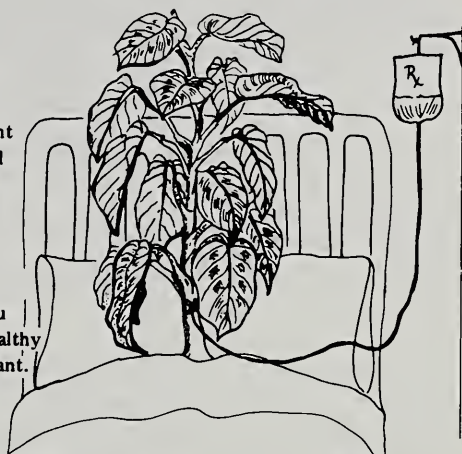


BORDERLINE PERSONALITY DISORDERS: THE CONCEPT, THE SYNDROME, THE PATIENT edited by Peter Hartocollis, M.D., Ph.D., International Universities Press, Inc., New York, 1977. 535 pp. Price \$22.50.

This comprehensive volume on the borderline patient is the compilation of papers presented at the International Conference on Borderline Disorders held in Topeka in March, 1976. Edited by Dr. Peter Hartocollis, Director of the C.F. Menninger Memorial Hospital, the contributions of over twenty-five clinicians and researchers reflect current concepts of genetics, heredity, dynamics, description, therapy, and prognosis of the borderline patient. The papers present the current animated debate over the borderline concept. Is the often wastebasket diagnosis of "borderline" actually borderline schizophrenia, or neurosis, or personality disorder, or none of these? By the final chapter, the reader is not necessarily more certain of what borderline is, but he has gained some help in recognizing, treating, and/or referring this by-no-means rare patient.

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In Part 3, Empirical Studies, Roy Grinker subdivides the borderline syndrome into four types on the basis of behavior including: 1) prevalence of anger, 2) defective affectionate relationships, 3) poor self-identity, and 4) depressive loneliness.

Part 4, Treatment Approaches, presents psychoanalytic oriented, behavioral, and pharmacologic treatment, usually in some planned alliance. Donald Klein favors heavy emphasis on drugs and a benign neglect of psychotherapy. His prescriptions of affect altering drugs, such as tricyclics, antidepressants, MAO-inhibitors, and lithium provide an approach to one emerging conceptualization of the borderline as an affective dysregulation.

Part 5, The Patient, is most interesting for case presentation by Furer and by Masterson, particularly for the latter's inclusion of the anorexia nervosa patient within the domain of borderline. The concept of the borderline patient is a difficult and involved one as evidenced by the profusion of writings, predominantly psychoanalytic, disagreeing even on nosology.

This book is the most complete offering of the current topics of debate within the field.

DENNIS M. YOUNG, M.D.

In Brief

Speakers on "Ask the Doctor"

Speakers for August 1978 on the Tuesday radio program (11:05 a.m., WDEL) produced by the Medical Society of Delaware are: August 1, *V. Terrell Davis, M.D.*, Marijuana and Mental Health; August 8, *Charles Depfer, D.O.*, PSRO & DELRO; August 15, *Conley L. Edwards, M.D.*, Breast Surgery, Radiation, and Chemotherapy; August 22, *Charles L. Miller, M.D.*, Asthma in Children; August 29, *Richard Lennihan, M.D.*, A Physician Looks at Running: Facts & Foolishness.

In the News

William T. Reardon, M.D., Wilmington, has been awarded the Mesmer Award by the Association to Advance Ethical Hypnosis, Pennsylvania Chapter, No. 2, Inc.

The new *Winder Laird Porter* Health and Social Services Center, named for the Wilmington physician, was dedicated June 19. The center replaces the Center City Service Center at 10th and Monroe Streets, Wilmington.

Student Clerkships

The Stroke Council of the American Heart Association is offering student clerkships in cerebrovascular disease to medical students. Three month stipend awards of \$1,500 each are available to institutions where clinical training in stroke is available to medical students. The deadline for receipt of applications is September 1, 1978. For information contact: Ms. Carol Maris, Division of Scientific Affairs, American Heart Association, 7320 Greenville Avenue, Dallas, Texas 75231. Telephone: (214) 750-5438.

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CLINICAL NOTICES AND MEETINGS

- Vascular Disease** The American Heart Association will present "VASCULAR DISEASE—MECHANISMS AND THE BASIS FOR THERAPY, August 16-19, at Hilton Head Island, South Carolina. The program meets the criteria for 10 hours in Category I of the Physician's Recognition Award of the AMA and 10 elective hours by the American Academy of Family Physicians. For information contact: American Heart Association, Vascular Disease—Mechanisms and the Basis for Therapy, 7320 Greenville Avenue, Dallas, Texas 75231.
- Care of the Child with Cancer** The American Cancer Society will present the NATIONAL CONFERENCE ON THE CARE OF THE CHILD WITH CANCER, September 11-13, in Boston, Massachusetts. There is no registration fee. The program has been approved for 15 hours' credit for the AMA Physician's Recognition Award and/or 15 elective hours by the American Academy of Family Physicians. For information contact: S. L. Arje, M.D., Childhood Cancer Conference, American Cancer Society, 777 Third Avenue, New York, New York 10017.
- Family Physician Conference** The American Academy of Family Physicians will hold its ANNUAL CONVENTION & SCIENTIFIC ASSEMBLY, September 25-28, in San Francisco, California. Participating physicians can earn one hour of prescribed AAFP credit for each hour spent in any portion of the scientific program. Advance registration is due by September 4. For information contact: AAFP, 1740 W. 92nd Street, Kansas City, Missouri 64114.
- Basis for Therapeutic Decisions** The University of Texas Health Science Center will present BASIS FOR MAKING THERAPEUTIC DECISIONS: UPDATE OF COMMON PROBLEMS, September 29-30, in Dallas, Texas. The program meets the criteria for 14 credit hours in Category I of the Physician's Recognition Award of the AMA. For information contact: Ms. Norma Wilcox, (214) 688-2166.
- Annual Clinical Congress** The American College of Surgeons will present the 64th ANNUAL CLINICAL CONGRESS, October 16-20, in San Francisco, California. The program meets the criteria for hour-for-hour credit in Category I of the Physician's Recognition Award of the AMA. For information contact: American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611. Telephone: (312) 664-4050, X324.
- Geriatric Medicine** The American Geriatrics Society, in conjunction with Franklin Square Hospital and the Health and Education Council will co-sponsor a SYMPOSIUM ON GERIATRIC MEDICINE, October 20-21, Hunt Valley Inn, Baltimore, Maryland. The program is acceptable for 14 hours of Category I under the Physician's Recognition Award of the AMA. For further information contact: William Reichel, M.D., Health and Education Council, 7201 Rossville Boulevard, Baltimore, Maryland 21237. Telephone: (301) 686-3610.
- Workshop on Sexuality** The Moss Rehabilitation Hospital will sponsor a WORKSHOP ON SEXUALITY AND THE DISABLED, October 20-22, Philadelphia, Pennsylvania. The program meets the criteria for 23 hours of Category I credit. For information contact: SAR Workshop Coordinator, Moss Rehabilitation Hospital, 12th Street and Tabor Road, Philadelphia, Pennsylvania 19141.

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**Adult Diabetes
Management**

The American Diabetes Association, Maryland Affiliate, will present **APPROACHING THE MANAGEMENT OF ADULT DIABETES**, October 25-26, Baltimore, Maryland. For information contact: Ms. Linda Warren, Health and Education Council, 7201 Ross-ville Boulevard, Baltimore, Maryland 21237. Telephone (301) 686-3610.

CLASSIFIED AD SECTION

Advertisements under the Classified Ad Section are charged at the rate of 30 words or less, set solid. One insertion \$4.00. Call the Journal office, 658-7596 for further information or placement. All advertisements are payable in advance. The Editorial Board reserves the right to edit copy. Closing date for new copy is the first of the month for inclusion in the current issue.

Classified advertisements of a professional nature are free to members.

PSYCHIATRIST: University of Delaware Student Health Service seeks an M.D. with completed psychiatric residency for a 9-month, half-time position assisting the full-time University psychiatrist in providing direct services to students. Position is available September 1, 1978. For information contact: C. Ray Huggins, M.D., Director, Student Health Services, Laurel Hall, University of Delaware, Newark, Delaware 19711.

STAFF PHYSICIAN: Full-time, 10-month position. Requires training and/or experience in Family Practice or Adolescent Medicine to deliver comprehensive

care to college students. Excellent working environment and fringe benefits. Competitive salary. Position available September 1, 1978. For information contact: C. Ray Huggins, M.D., Director, Student Health Services, Laurel Hall, University of Delaware, Newark, Delaware 19711. Telephone: (302) 738-2226.

SITUATION WANTED: R.N. desires nursing position in Newark or Wilmington physician's Office. One and a half years Medical-Surgical and Ob-Gyn experience and six months O.R. experience. If interested, please contact: Cindy Halpern, R.N. 798-0866.

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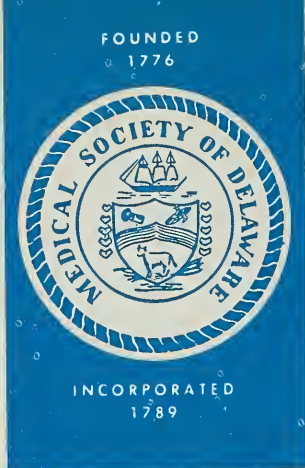
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AUGUST, 1978

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cancer communiqué

FROM THE DELAWARE CANCER NETWORK*

REPORT OF THE SECOND REGIONAL NURSES' CONFERENCE JUNE 15-16, 1978

JOANNE P. TULLY, R.N., M.P.H.

The Hotel duPont was the site of this year's Regional Nurses' Conference on "Management of the Patient with Colon and Rectal Cancer: Implications for Nursing." Approximately 85 nurses and other health care professionals attended the continuing education program held on June 15 and 16, 1978. The two-day program was sponsored by the Delaware Cancer Network, the University of Delaware College of Nursing, and the American Cancer Society, Delaware Division, Inc.

The sessions were designed to assist nurses and supportive health care personnel to gain insight and technical information about the diagnosis, care, treatment, and rehabilitation of the patient with colo-rectal cancer. The first day of the program offered technical information with regard to diagnosis and treatment of the problem.

Leslie W. Whitney, M.D., surgeon and Director of the Delaware Cancer Network, opened the morning session with an overview of the problem, reviewing national and state statistics as well as some of the epidemiological factors believed to be involved in the etiology of this disease site. Dr. Whitney related that although the cause of colo-rectal cancer, like most other cancers, is unknown, statistics show evidence of a correlation between cancer of the colon and chronic ulcerative colitis and congenital multiple polyposis.

Dr. O. Keith Hamilton, Dover surgeon, discussed the diagnostic workup of a patient with rectal bleeding. Dr. Hamilton enumerated the

methods available to detect colo-rectal bleeding and diagnose the problem, along with indications for use of each method and its benefits. Particular attention was paid to one newer method being used, fiberoptic colonoscopy.

Although surgery is the most effective of the current methods available for treating colo-rectal cancer, radiation therapy and chemotherapy, in combination with surgery, are being used in some cases. Horace Whiteley, M.D., Attending Surgeon of the Colo-Rectal Service at Memorial Sloan-Kettering Hospital in New York City, presented the surgical aspects of treatment intervention. Dr. Whiteley placed emphasis on the fact that the extent of the surgery depends on the specific site of involvement and on the type and stage of the disease. Duke's classification for staging was presented, and its importance in planning treatment was stressed.

Radiation therapy is proving effective in reducing the size of some colo-rectal tumors, helping prevent the spread of the disease and relieving pain. Ekkehard S. Schubert, M.D., a radiotherapist at the Wilmington Medical Center, discussed the use of radiotherapy in several patient cases, preoperatively and postoperatively, impressing on the audience that each case is different and requires individual treatment. Alma Hayes, R.N., B.S.N., and Kathryn Martin, R.N., B.S.N., radiation oncology nurses of the Oncology Clinical Center at Johns Hopkins Hospital, shared with the participants the emotional, psychosocial, and physical components to the nursing assessment and subsequent care given to patients receiving radiation therapy for treatment of their disease.

Ms. Tully is Senior Nurse Coordinator for the Delaware Cancer Network.

*An NCI-supported agency located at 1200 Jefferson Street, Wilmington, Delaware 19801. Tel. (302) 428-2113.

Management of the patient with chemotherapy was presented by Nancy Domenick, R.N., B.S.N., G.I. oncology nurse clinician of the University of Chicago Hospital. Mrs. Domenick discussed specific chemotherapy regimens utilized in the treatment of colo-rectal cancer. During her presentation, Mrs. Domenick related some of the side effects and the nursing implications in administration of the drug therapies and in caring for the patient on an outpatient basis.

The second day's programming began with Janet MacLean Long, R.N., E.T., discussing the nursing management of the surgical patient. Mrs. Long identified several emotional and physical components that are part of a nursing assessment and several points of intervention. As an enterostomal therapist, Mrs. Long is able to work preoperatively with surgical patients who will have resulting stomas, as well as with their surgeons. Stoma placement can be outlined at this point so that it does not interfere with the waistline, other surgical scars or incisions, bony prominences, the umbilicus, or skin folds, which would only cause further problems—physical as well as emotional. Assisting the individual to care for himself after surgery and to resume his normal activity is of utmost importance in delivering nursing care.

Because of the multifaceted problems that the person with a diagnosis of colo-rectal cancer faces, multidisciplinary can become actively involved in offering comprehensive care. In response to this concept and a concern for several specific nursing intervention points, workshop sessions were held. This gave participants the opportunity to join in group discussions on a nursing topic of concern to them. Workshop topics included discussion of the nurse's role in preparing the patient for sigmoid- and colonoscopy, nutritional concerns, home care innovations, sexuality, skin care, and available appliances for the ostomate.

For the 85 participants in this year's conference who represented four states and six different health care disciplines, information received may help them to plan and implement effective care to meet the specialized needs of individuals being treated for colo-rectal cancer and their families.

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DESCRIPTION Each yellow, scored tablet contains 4.50 mg. oxycodone HCl (WARNING: May be habit forming), 0.38 mg. oxycodone terephthalate (WARNING: May be habit forming), 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.

INDICATIONS For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS Hypersensitivity to oxycodone, aspirin, phenacetin or caffeine.

WARNINGS Drug Dependence Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of PERCODAN®, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, PERCODAN® is subject to the Federal Controlled Substances Act.

Usage in ambulatory patients Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using PERCODAN® should be cautioned accordingly.

Interaction with other central nervous system depressants Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with PERCODAN® may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

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Usage in children PERCODAN® should not be administered to children.

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PRECAUTIONS Head injury and increased intracranial pressure The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions The administration of PERCODAN® or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special risk patients PERCODAN® should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

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ADVERSE REACTIONS The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

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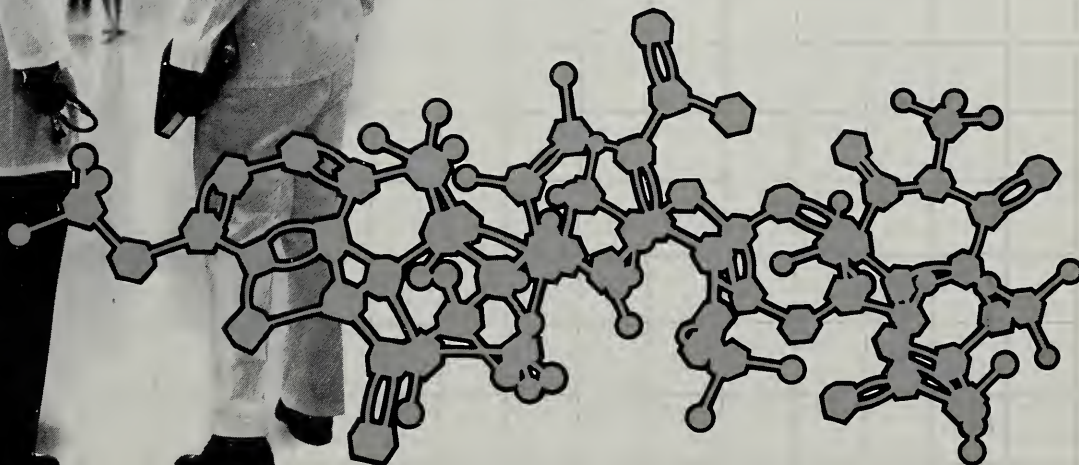
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Manuscripts

All manuscripts submitted shall be original, never before published and contributed solely to the Delaware Medical Journal. They should be addressed to the Editor, 1925 Lovering Avenue, Wilmington, Delaware 19806, who reserves the right to reduce, revise, or reject any material submitted for publication.

Copy should be typewritten, double-spaced on 8½" x 11" white bond paper. In addition to the original, two copies are desirable.

The professional affiliations of each author should be supplied. Uncommon abbreviations should be written out in parentheses the first time they are used. Names, initials, or other information that could identify a patient should be eliminated from the copy. If photographs of patients are used, either the subjects should not be identifiable, or their pictures must be accompanied by written permission to use the figure.

Review and Action

Manuscripts are customarily examined by the editorial staff and sent out to two reviewers. Authors are usually notified within two to six weeks as to the acceptability of a manuscript, but sometimes longer delays are unavoidable.

Contributors will be notified as soon as a manuscript is received. Unaccepted manuscripts will be returned.

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References should conform to the Index Medicus, including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher and place of publication, as well.

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1. Fine RN, Brennan LP, Edelbrock HH, et al: Use of pediatric cadaver kidneys for homotransplantation in children. JAMA 210:477-484, 1969.

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(2) Morgan WL, Engel GL: The Clinical Approach to the patient, p 85. Philadelphia, WB Saunders Co, 1969.

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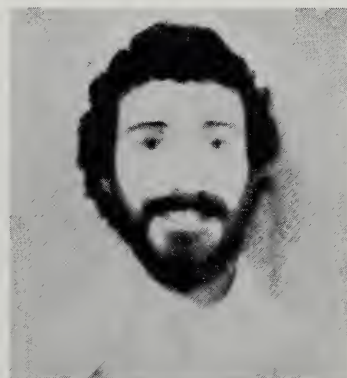
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New Members



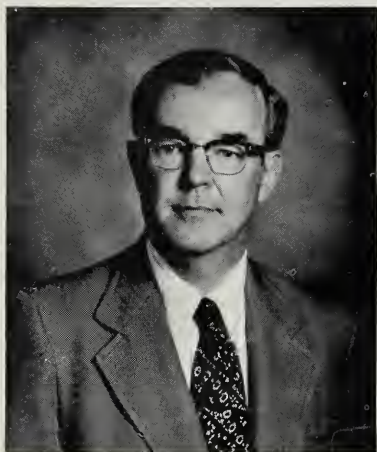
Joseph A. Kuhn, M.D., is a graduate of Jefferson Medical College, '73. He interned at the Wilmington Medical Center and served a residency in internal medicine at the same institution. He is currently serving a Fellowship at Georgetown University Hospital in nephrology. He is board certified in internal medicine. He will be practicing at 2300 Pennsylvania Avenue, Wilmington. Doctor Kuhn is planning to move to Wilmington in July with his wife and two children. He enjoys photography, model railroading, tennis, and softball. Doctor Kuhn was a recipient of a Medical Society of Delaware Scholarship during his years at Jefferson Medical College.

William A. Meyer, Jr., M.D., an alumnus of the University of Delaware, is a 1974 graduate of Jefferson Medical College. He served his residency in obstetrics-gynecology at Maryland General Hospital and George Washington University Medical Center. Doctor Meyer is currently practicing in Swain Acres, Georgetown, and lives with his wife in Rehoboth Beach.



Eugene A. Jaeger, M.D., graduated from Jefferson Medical College in 1953. He interned at Jefferson Medical College Hospital and served his residency in psychiatry at Norristown State Hospital. His office is located at No. 1 Pike Creek Center, Wilmington. Doctor Jaeger lives in Devon. His hobbies are antiques, bread baking, photography, gardening, golf, tennis, aerobic jogging, swimming, hunting, poem writing, fishing, sailing, and clam digging.

A. Robert Masten, M.D., graduated from the University of Maryland School of Medicine, '73. He served his internship and residency at the University of Maryland Hospital and is board certified in internal medicine. Doctor Masten has returned to his hometown, Milford, where he and his wife, Elizabeth F. Masten, M.D., live with their two children, and practice at 509 Lakeview Avenue. Dr. Elizabeth Masten is a dermatologist.



President's Page

PASSAGES

During my tenure, which has moved so fleetingly, I have endeavored to stress the need for all of us to work together to improve our image with the public, to prevent bad or harmful legislation from becoming law, and, above all, to diligently fulfill our commitment to the community in terms of both our professional specialty and everyday citizenship.

We share a unique calling that demands high standards of training and dedication. When we cooperate with each other to achieve greater excellence, then the whole Delaware community is the beneficiary. That has been my message and my aspiration. I thank all of you for everything you have done to help bring it about.

Let me say that I have found a spirit of cooperation with our goals throughout Delaware. The government, the media, the hospitals, and other institutions, both public and private, have shown a clear willingness to strive constantly toward the improvement of health care which is our ongoing challenge.

Meeting that challenge will continue to be my personal hope as I step down from the presidency of the Medical Society of Delaware, and in that cause I pledge my very best wishes and efforts to Dr. Anthony Cucuzzella and to his successors in the years to come. My final appeal is for every other member to do the same.

John J. Egan, M.D.

MEDICAL SOCIETY OF DELAWARE

1776-1789-1978

189th ANNUAL MEETING

September 22 and 23, 1978

P R O G R A M

September 22

HOUSE OF DELEGATES

**Delaware Academy of Medicine Building
1925 Lovering Avenue
Wilmington, Delaware**

8:30 A.M. REFERENCE COMMITTEES
12:00 LUNCHEON
1:30 P.M. HOUSE OF DELEGATES
5:00 ADJOURNMENT

September 23

**Hotel duPont
11th and Market Streets
Wilmington, Delaware**

PRAYER BREAKFAST

7:15 A.M. Hotel duPont, DuBarry Room, 11th & Market Streets, Wilmington

SCIENTIFIC SESSION

8:15 A.M. REGISTRATION — EXHIBITS — Foyer
9:00 CALL TO ORDER — John J. Egan, M.D., President, Medical Society of Delaware
Report of the House of Delegates — Joseph E. Belgrade, M.D., Secretary, Medical Society of Delaware
9:00 FOR YOUR SPOUSES: DuBarry Room
ASSERTIVENESS: TECHNIQUES OF EFFECTIVE COMMUNICATION
Susan Drury, Ph.D., Clinical Psychologist, University of Delaware
9:10 INTRODUCTION OF SCIENTIFIC PROGRAM
Lanny Edelsohn, M.D., Chairman, Program Committee
9:15 THE DISCOVERY OF QUEEN TIYE: QUEEN OF THE XVIII DYNASTY
James E. Harris, D.D.S., M.S., Professor and Chairman, Department of Orthodontics,
The University of Michigan School of Dentistry
10:15 INTERMISSION — VISIT EXHIBITS
10:45 EVOLUTION AND DIABETES
George F. Cahill, Jr., M.D., Professor of Medicine, Harvard University Medical School
11:45 BUSINESS MEETING

- 12:15 LUNCH — DuBarry Room — Christiana Room
- THE PHYSICIAN IN A SECOND CAREER
Robin Cook, M.D., author of book and Movie, *COMA*
- 2:00 P.M. THE DISCOVERY OF AUSTRALIA ANTIGEN AND ITS RELATION TO
HEPATITIS B
Baruch S. Blumberg, M.D., Ph.D., Associate Director for Clinical Research, The Institute for Cancer Research
- 3:00 WILL MR. X PLEASE COME FORWARD?
Wilton M. Krogman, Ph.D., LL.D., D.Sc., Director, H. K. Cooper Institute for Oral-Facial Anomalies and Communicative Disorders and the Lancaster Cleft Palate Clinic
- 4:00 ADJOURNMENT

DINNER DANCE

Hotel duPont
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- 6:30 P.M. Cocktails
7:30 Annual Banquet
Invocation — Chaplain Lynwood Swanson
Dancing 'till 12:00 — The Al Morrow Band

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Program is acceptable for seven prescribed hours by the American Academy of Family Physicians. Seven credit hours in Category I of the Physician's Recognition Award of the American Medical Association have been applied for.

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IN TRIBUTE

At the House of Delegates meeting the Medical Society of Delaware will pay tribute to the following physicians who graduated from medical school 50 years ago.

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Caziville L. Hudiburg, M.D.	1928	Joseph M. Messick, M.D.	1928
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GENETICS AND DIABETES MELLITUS

GARY G. CARPENTER, M.D.

In attempts to explain the inheritance of diabetes,¹ many workers in the field have begun to subdivide the disorder. Simplification dies hard, adding to the difficulties of understanding the varieties of diabetes mellitus as they exist today. The general backlog of genetic information already published about diabetes as a single entity has compounded the confusion and increased the resistance to change.

The fact is that diabetes mellitus is at least several and perhaps many diseases. The modes of inheritance of some of these diseases are sometimes known quite well; as a rule they are better understood when the particular disease associated with the diabetes mellitus is rare. On the other hand, the most common varieties of diabetes cause the most trouble to the clinician who tries to explain the risk of inheritance to an inquiring relative.

The disease of diabetes mellitus which affects the greatest number of people has been recorded by Rimoin and Schimke as a familial disorder,¹ but arguments still continue about the postulated modes of inheritance.¹⁻³ The risk to the general population of acquiring diabetes mellitus is about 0.128%. If the onset of diabetes was from 0 to 19 years, the diabetic's siblings have a

risk from ten to 14 times greater than the risk in the general population. (Table 1) The risk of the offspring developing diabetes is 18 to 41 times this general risk; parents of the young person with the disease have two to three times the general risk. In other words, the risk is roughly 2 to 4% for the offspring and 0.4% for the parents.

Also, if the age at onset of diabetes in the individual is between 20 to 39 years, the risk of brothers and sisters contracting the disease is four to five times the general population risk; of the offspring of this slightly older person contracting the disease, six to 13 times, and again, the parents' risk is the same, two to three times the general numbers. For the person 40 years and over, the risk of brothers and sisters getting the disease has now diminished to two to four times the general population risk, for their offspring one to three times, and for their parents, again the same, two to three times. A slightly more recent reference by Fuhrmann suggests that the most important single factor to be considered in relation to the inheritance of relatives of that patient is the age of the patient at the onset of diabetes.³ (pp 234-239) (Table 2)

If the person questioning whether he will get it is 25 years old, the general population risk of 0.2 to 0.3% increases to 8% if the questioner is related to a person who got diabetes under the

Dr. Carpenter is Associate Professor of Pediatrics, Jefferson Medical College of Thomas Jefferson University.

This paper was adapted from a presentation to the Department of Medicine, Wilmington Medical Center, Wilmington, Delaware.

TABLE 1
RISK OF ACQUIRING DIABETES MELLITUS IN RELATIVE
OF DIABETIC CORRELATED WITH AGE OF ONSET OF DIABETES

Age of Diabetic at Onset	Siblings	Added Risk of Getting Diabetes for Offspring	Parents
0-19	10 to 14 times risk	18 to 41 times risk	2 to 3 times risk
20-39	4 to 5 times risk	6 to 13 times risk	2 to 3 times risk
40-	2 to 4 times risk	1 to 3 times risk	2 to 3 times risk

age of 25 and to about 1% if his relative became diabetic over the age of 25. If a person is 45, the general population risk has increased to 0.5 to 0.9%, and if the questioner has a relative under 25 who has diabetes, his risk increases to 13%; if he has a relative over 25 with it, it is 2%. For persons 65, the general risk of getting diabetes is 1.7 to 3.8%. This increases to 17% if they have a relative who has contracted diabetes under the age of 25. The risk is increased only to 9% if they have a relative who was over 25 when he got the disease. If a person is 85 years old, the general risk of getting diabetes is 1.4 to 9.2%; with a closely related relative with diabetes (as all the other diabetics have been to these patients) under 25 years, the risk that this 85-year-old will get the disease is increased to 25%; if the relative was over 25 when his diabetes developed, the risk is 21%. Although this 25% risk appears to be relatively high, this is a most special circumstance, limited to 85-year-old persons. The usual risk of getting diabetes when one has a close relative of undetermined age with the disorder is less than 10%.

Identical twins have slightly higher risk figures. If one identical twin (of twins under 40 years of age) gets diabetes mellitus, the other identical twin may expect to get diabetes with about a

40 to 50% chance. If the identical twins are over 40 when one contracts diabetes, then the risk of the other twin contracting the disorder is much higher, approaching 100%.³ (pp 234-239)

If two diabetics marry (conjugal diabetics), the risk for their offspring to have diabetes is between 6 and 10%. If the parents had diabetes of the juvenile variety, requiring insulin, long before they married, the risk is slightly increased for their children as they grow older.

It is of importance to recognize that with an understanding of the percentages mentioned above, unless a family with two parents with diabetes has twice as many children as a family with one parent with diabetes, the marriage of two diabetics will not increase the total number of children with diabetes in the population.

In addition to the figures mentioned above, there are almost 30 rare disorders which may be associated with mild diabetes mellitus or abnormalities of glucose tolerance. In this group of disorders the risk of diabetes is generally increased over the previously cited numbers.¹ The list includes cystic fibrosis, several types of muscular dystrophy, some unusual ocular disorders, and the recently popularized Prader-Willi syndrome, which includes extreme obesity, short

TABLE 2
RISK OF ACQUIRING DIABETES MELLITUS IN RELATIVE OF
DIABETIC ACCORDING TO AGE OF RELATIVE

Age of Diabetic Relative	Age of Questioner			
	25	45	65	85
Pop. Risk	0.2-0.3%	0.5-0.9%	1.7-3.8%	1.4-9.2%
Under 25	8%	13%	17%	25%
Over 25	1%	2%	9%	21%

stature, and gonadal abnormalities. These and other rare endocrine, genetic, and chromosomal disorders added with those already mentioned, make up much less than 5% of the patients recognized to have diabetes mellitus.

Genes require an appropriate environment to express themselves; environmental influence should be added to risk figures. Being overweight enhances the appearance of diabetes mellitus. While other mild environmental influences may also affect whether the disease is diagnosed or not, extreme obesity and dietary indiscretion are the most prominent of the environmental factors increasing the chances of getting diabetes.

Quite recently Doctor Tattersall has described a type of diabetes that appears in juveniles but is not so severe as that previously known.⁴ It may or may not require small amounts of insulin, and patients with this particular variety of diabetes mellitus have rarely, if ever, suffered ketoacidosis. Furthermore these patients may go for long periods of time without any insulin whatsoever while still maintaining their blood sugar only moderately elevated and without becoming ill. This disorder, much more rare than the usual diabetes mellitus, is inherited in a very specific fashion, passing through families in an autosomal dominant form. A father or mother, a son or daughter, and a grandson or granddaughter may present with the disease. When this particular family history exists and a mild disorder appears in a young person, the risk of that person having children with the same form of diabetes may be as high as 50%.

As Doctor Neel has remarked, "Diabetes has been and continues to be a geneticist's nightmare." With the recognition of the varieties of disorders that may be associated with diabetes mellitus and the newer figures that more clearly, albeit with complexity, often define the lower risks of relatives getting the disorder than had previously been expected, we may be finally awakening from the bad dream.

REFERENCES

1. Rimoin DL, Schimke NR: Genetic Disorders of the Endocrine Glands. St. Louis, CV Mosby Co, 1971.
2. Rubenstein PS, Nicholson JF: Close genetic linkage of HLA and juvenile diabetes mellitus. *NEJM* 297:1062, 1977.
3. Creutzfeldt W, Koerberling J, Neel JV (eds): The Genetics of Diabetes Mellitus. New York, Springer-Verlag, 1976.
4. Tattersall RB, Fajans SS: A difference between the inheritance of classical juvenile onset and maturity onset of diabetes in young people. *Diabetes* 24:44-53, 1975.

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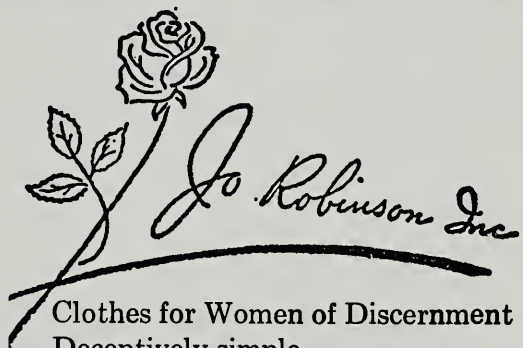
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URINARY TRACT INFECTIONS IN CHILDREN FROM THE PERSPECTIVE OF A PEDIATRIC UROLOGIST

A. BARRY BELMAN, M.D.

Introduction

Certain statistics which bear repeating have been established in reference to the incidence and significance of urinary tract infections in children. The risk of a girl having a urinary tract infection during her school career is almost 5%.¹ If all girls with documented infection are evaluated radiographically, one-third or more will be found to have significant anatomic abnormalities of the urinary tract, the most common being vesicoureteral reflux.²

See Highlights on page 447.

I have the impression that most primary care physicians think of urinary infections in children as occurring at about three years of age. In view of the fact that the onset of verbalization and expectations for toilet control both peak at this age, that feeling is understandable. Recent evidence indicates, however, that the risk of urinary infection in children well under three years of age is as high as that for the older group.³

With all of this in mind I would like to pass on a few observations:

1. Only a segment of the pediatric population with urinary infections is at risk for pyelonephritis, and virtually all of these have vesicoureteral reflux.
2. Of those with clinical evidence of pyelonephritis (symptoms of systemic toxicity, high fever at the time of urinary infection), few will ever develop renal scarring.

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This paper was adapted from a presentation to the Department of Pediatrics, Wilmington Medical Center,

3. Older children who were at risk for scarring already have radiographic changes by the time they present for urologic evaluation⁴ because the infant kidney is most susceptible to pyelonephritic scarring.²

4. If we are to prevent renal scarring, we must identify those at risk in infancy.

Diagnosing Urinary Tract Infection

Most authorities agree that diagnosing urinary tract infection by routine urinalysis alone is unreliable.⁵ On the other hand, immediate plating of fresh urine and confirmation of a positive culture by a second urine culture prior to treatment virtually assure the accuracy of the diagnosis.⁶

It is not desirable to perform a urine culture on a specimen brought from home unless the family is carefully instructed how to collect the urine and the urine is kept refrigerated until it can be plated. If collection of a fresh specimen on our premises is impossible, we usually recommend that the sealed container with specimen be placed in a plastic kitchen bag with ice during transportation until it can be plated.

There are many simple, inexpensive office methods for performing urine cultures. In the otherwise healthy child whose only complaint is lower urinary symptoms, it is ideal to carry out two cultures to prove the diagnosis before initiating treatment. These can be done on two consecutive days or with two separate, fresh specimens collected on the same day several hours apart. Two positive cultures (greater than 10^5 or 100,000 colonies/ml) of the same organism confirm urinary infection. Growth of fewer than 100,000 colonies/ml should be looked at skeptically, regardless of symptoms. Absolute con-

firmation in this situation may be attained by means of a suprapubic bladder aspiration in children under three years of age, or by urethral catheterization in older patients.

The typical symptoms of lower urinary tract irritability plus gross or microscopic hematuria would initially appear to be *prima facie* evidence of bacterial urinary infection, regardless of culture results. This is not, however, the case. One must always keep in mind that viral urinary infections, primarily caused by adenoviruses 11 and 21, also occur. As there is no evidence of a higher incidence of underlying anatomic pathology in this group as compared to the general population, radiographic evaluation does not appear to be indicated.⁷ Routine bacterial cultures are negative with viral infections.

Screening Cultures

Mass screening for urinary tract infection is probably not justifiable on the basis of cost. On the other hand, screening as part of well baby care in the pediatrician's office is inexpensive and is recommended. Many primary physicians already do this. The majority, however, perform screening cultures only when a child has reached the age of three years. Since the prevalence of urinary infections is 2 to 3% in both preschool and school-age children,⁸ urine cultures done on a regular basis in the pediatrician's office appear to be justified also in the younger groups.

It is becoming apparent that the infant kidney is most susceptible to damage from infection. Whereas older children and adults with otherwise normal urinary tracts tolerate renal infection with little or no recognizable damage, the infant has serious potential for scarring and interference with further renal growth from bacterial invasion.⁹ If we are to prevent renal damage in the children who are at risk, the diagnosis of urinary tract infection must be made at an early age. If cultures have not been carried out on a routine basis, they become mandatory in all children who present with any sign of possible infection, ie, poor feeding, diarrhea, weight loss, colic, excessive irritability, or, most commonly, fever.

Treatment of Acute Urinary Infection

Fortunately, the otherwise normal urinary tract clears infection readily so a little antibacterial

medication goes a long way. The use of the least expensive, best tolerated, least toxic antibacterial agent to which the organism is sensitive (eg, sulfonamide) for a total of ten days of treatment, with the medication given three times daily in a dose appropriate for age, is recommended. If symptoms persist after five days, culture should be repeated. Otherwise, it is my practice to check the urine by culture two weeks after cessation of therapy. Others recommend repeating the culture at 48-72 hours to confirm treatment effectiveness.^{5,10}

If the child has a febrile urinary tract infection, medication is continued on a three times daily schedule (usually one tsp, tid) until radiographic evaluation is carried out, since the chance of a significant recurrence or abnormality is 60%.² While the patient is on maintenance therapy, the urine should be recultured after two weeks to ascertain that treatment has been effective.

Urinary Tract Evaluation

Although many different guidelines exist concerning the use of urinary x-rays, it has become my policy to recommend intravenous urography and awake cystography (with voiding films in boys) in every child in whom a urinary infection has been reliably culture-documented. One must keep in mind that the first culture-documented infection in a child stands a good chance of *not* being her first urinary tract infection. An infection documented in infancy (which may truly be the child's first infection) provides all the more reason to proceed with the evaluation as soon as possible. The chance for discovering a urinary abnormality in infants with urinary infection has been reported to be as high as 90%.¹¹ It is at this stage that it would be most desirable to identify that child at risk.

Today it is accepted policy to delay radiographic evaluation for about six weeks until the infection has been eradicated. Acute inflammatory changes will by then have resolved, and transient reflux brought on by edema at the ureterovesical junction is less likely to be present. As mentioned earlier, children who have febrile infections have a 60% incidence of reflux. To obviate the risk of further renal infections, they should be kept on medication until x-rays are carried out.

It must be noted that the evaluation of the child with infection not responsive to standard treatment becomes more urgent. This holds particularly true for newborns and infants. Performance of the cystogram may not be urgent, but it is essential to rule out ureteral obstruction. Unfortunately, some physicians who believe strongly in waiting six weeks before radiographic evaluation fail to act more quickly in the patient with unresponsive infection, a situation in which underlying anatomic pathology is most likely.

Radiographic Studies

Intravenous urography and cystography are essential in the evaluation of the child with

proven infection. A normal intravenous urogram is reassuring but does not guarantee absence of urinary pathology. Both vesicoureteral reflux (Figure 1) and urethral obstruction (Figure 2) may be missed if a cystogram is not obtained. These studies do not require hospitalization and are only minimally invasive. The cystogram, done by gentle insertion of a well-lubricated, small feeding tube or urethral catheter, is essential for the diagnosis of reflux. Along with a voiding film in boys, it is the best means of diagnosing urethral pathology. Voiding films *in girls* are of less importance since the urethral configuration radiographically has little proven clinical significance and true urethral obstruction



FIGURE 1a

Intravenous urogram in girl with urinary tract infections. Note duplication of collecting system bilaterally with blunting of lower segment calices.

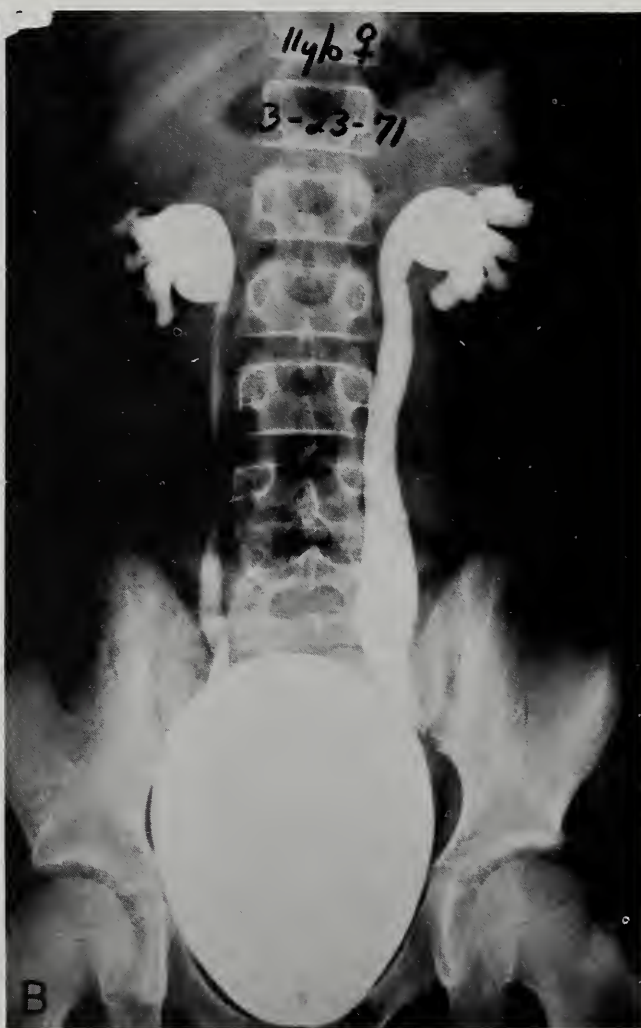


FIGURE 1b

Cystogram with bilateral vesicoureteral reflux into lower collecting systems bilaterally.



FIGURE 2a

Intravenous urogram in eight-year-old boy with a single urinary infection. Normal!

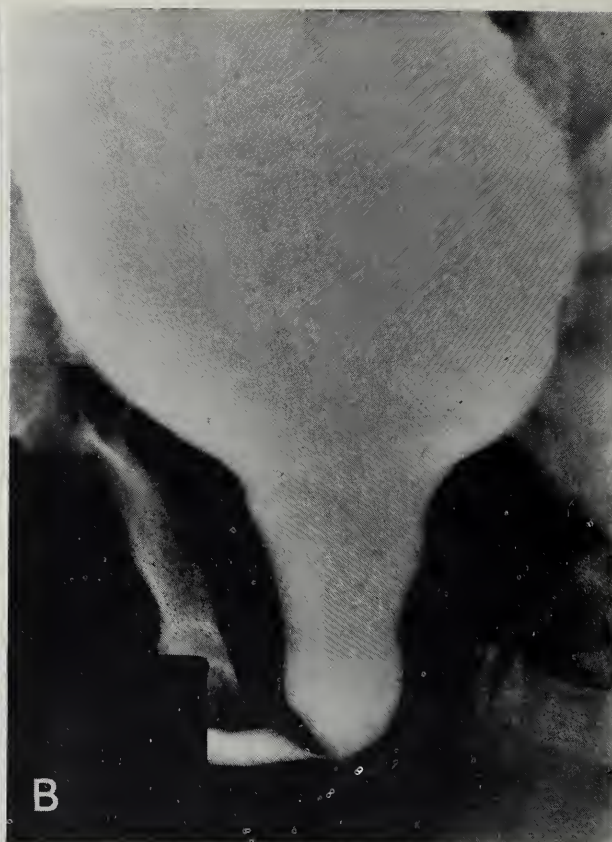


FIGURE 2b

Voiding cystourethrogram in same boy demonstrating obstructive posterior urethral valve.

virtually never exists (an opinion not universally shared).

Recent advances in nuclear medicine have greatly contributed to our ability to evaluate the urinary tract more safely. Aside from renal scanning, which in newborns is a much more sensitive method of determining renal function and of identifying renal masses than standard pyelography (Figure 3), the addition of isotope cystography enables us to follow the patient with vesicoureteral reflux at one one-hundredth the radiation exposure of standard x-ray techniques. (Figure 4) In girls, an intravenous pyelogram in conjunction with an isotope cystogram is an alternative approach in initial evaluation since vesicoureteral reflux is the most common abnormality to be found. If the IVP is abnormal, a standard cystogram may later be elected for additional evaluation. After the initial workup, all follow-up cystograms in the patient with vesicoureteral reflux should ideally be of the isotope variety in order to limit radiation exposure.¹²

Urologic Evaluation

To me it is apparent that the caliber of the bladder neck,¹³ urethra,¹⁴ and urethral meatus¹⁵ plays no role in the incidence of urinary infections in children other than the occasional male child with fine urethral narrowing. Because of this and my personal experience of having never gained unexpected information by performing cystoscopy in children with normal x-ray studies and uncomplicated urinary infections, it is not my policy to recommend endoscopy in this group of patients. On the other hand, cystoscopy, retrograde pyelogram, a sleep cystogram, or other studies are justifiable in children with uncontrollable infections, or for those whose kidneys or ureters cannot be visualized by non-invasive means; these situations occur rarely.

Chronic Cystitis

About 8% of girls with recurrent cystitis have bladder changes defined as cystitis cystica.¹⁶ This condition is the response of the bladder to

Summary and Conclusions

Urinary tract infection in children is a common problem. Although it rarely represents a serious health threat, such infection may indicate underlying anatomic pathology and continued morbidity. Thorough radiographic evaluation is mandatory; it should be carried out six weeks following control of the first urinary infection. In infants inability to suppress bacteriuria and urinary infection associated with sepsis indicates the need for earlier, urgent evaluation. Bacterial urinary infection associated with vesicoureteral reflux subjects the kidney to the risk of pyelonephritis and secondary scarring. Infants appear to be more susceptible to permanent damage of this type than older children or adults.

Frequent cystitis unassociated with fever, particularly in small girls, has the potential of interfering with toilet training. Early institution of long-term prophylaxis may prevent difficult problems with enuresis in the future. Chronic cystitis in the form of cystitis cystica is the result of protracted, uncontrolled infection. Many years of medication and bladder retraining be-



FIGURE 3

Radioisotope renal scan in newborn with right flank mass. Poor pickup of isotope on right side (study done posteriorly so right kidney is to reader's right). Diagnosis: right idiopathic renal vein thrombosis.

recurrent, uncontrolled, or unrecognized infection. It is characterized by small, mucosal cysts most commonly located at the bladder neck and trigone. These children often present with day and night wetting. They frequently complain of intermittent lower abdominal pain and may squat when they have the urge to urinate, sitting on the heel of one foot in an attempt to stay dry.

These children require long-term therapy. My policy is to recommend continuous medication for at least one year. Experience with either sulfisoxazole or nitrofurantoin, administered three times daily, has been most gratifying.¹⁷ Others have kept similar patients free of infection, once the acute infection has been controlled, by small doses of trimethoprim-sulfamethoxazole, using one-half teaspoon of the suspension at bedtime. If infection recurs within a few months following cessation of antimicrobials, another year of treatment is recommended. These girls ultimately tend to outgrow their inclination for infection at puberty although they appear to be at higher risk for infection when becoming sexually active.



FIGURE 4

Radioisotope cystogram demonstrating significant bilateral vesicoureteral reflux.

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come necessary to prevent bacteriuria and to establish continence in this difficult group.

REFERENCES

1. Kunin CM: Urinary tract infections in infancy, editorial. J Pediatr 86:483, 1975.
2. Govan TE, Fair WR, Friendland BW, et al: Management of children with urinary infections. Urology 6:273, 1975.
3. Randolph MF, Morris KE, Gould EB: The first urinary tract infection in the female infant. J Pediatr 86:342, 1975.
4. Winberg J, Bergstrom T, Jacobsson B: Morbidity, age and sex distribution, recurrences and renal scarring in symptomatic urinary tract infection in childhood. Kidney Int 8:S-101, 1975.
5. Margileth AM, Pedreira FA, Hirschman GH, et al: Urinary tract bacterial infections. Pediatr Clin North Am 23:721, 1976.
6. Kass EH: How and why to treat urinary infections. Hosp Med May 1968.
7. Mufson MA, Zollar LM, Mankad UN, et al: Adenovirus infection in acute hemorrhagic cystitis. Amer J Dis Child 121: 281, 1971.
8. Walker RD (Chm): Screening school children for urologic disease. Section on Urology, American Academy of Pediatrics. Pediatrics 60:239, 1977.
9. Saxena SP, Lawrence BM, Shaw DG: Justification for early radiological investigation of UTI in children. Lancet II: 403, 1975.
10. Rapkin RH: Urinary tract infection in children. Pediatrics 60:508, 1977.
11. Lynch J, Maxted W: Urological evaluation of infants, observations gleaned. Presented at the 35th annual program of the Mid-Atlantic Section of the American Urological Association, Hot Springs, Virginia, Oct 26-29, 1977.
12. Conway JJ, Belman AB, King LR, et al: Direct and indirect radionuclide cystography. J Urol 113:689, 1975.
13. Straffon RA: Urinary tract infection. Med Clin North Am 58:545, 1974.
14. Walker RD, Richard GA: A critical evaluation of urethral obstruction in female children. Pediatrics 58:545, 1974.
15. Stephens FD: Urological aspects of recurrent UTI in children. J Pediatr 80:725, 1972.
16. Vlatkovic G, Bradic I, Gabric V, et al: Cystitis cystica: characteristics of the disease in children. Br J Urol 49:57, 1977.
17. Belman AB: The clinical significance of cystitis cystica in girls: results of a prospective study. J Urol 119:661, 1978.

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CORRUPTING THE AMERICAN PHYSICIAN

J. LLOYD JOHNSON

The practice of medicine has, from the earliest days of society, been considered a profession. Professionals are accorded a special status because they have a responsibility for those who employ their services which is not shared by most individuals in a society. An individual seeks medical treatment sufficiently infrequently and the healing arts are sufficiently complex that the caveat emptor rule, which governs ordinary purchases, does not work. If one gets a bad haircut or does not like the fee, one seeks out a different barber, but one's appendix can be removed only once.

The professional exists and functions effectively because of the myth that he places the interest of his patient ahead of his own. A myth is not fiction: it consists of facts that are continually repeated and can be observed over and over again. The myth works because both the physician and the patient believe it. The medical myth has a foundation of reality which, until recently, has been reinforced constantly from the days of antiquity.

"Physician" comes from the Greek word for nature, whose stem means "to grow;" "being" is derived from the same stem. The archetypal image of the physician is that of a philosopher concerned with the nature of being, ie, the whole man. This archetype fulfills itself not only psychically in the physician, but also objectively in the world of physician-patient relationships. The medical myth is (or was) solidly based on a triad of factors involving the patient's interest: his physiologic, psychologic, and economic health.

Much has been learned about the existence,

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role, and importance of myths in Western culture since the investigations launched by Carl Gustav Jung during World War I. Myths may be defined as precious vessels that hold some of our fundamental archetypal beliefs. Collectively, myths help to hold our culture together. When a myth (vessel) is cracked, those beliefs are diffused into the undifferentiated surrounding matter, with a resulting decline in stability of the relevant culture.

Most American physicians consciously emulate the myth that calls for the physician to accept responsibility for not only the physiologic health of his patients but also for the psychologic and economic effects of his diagnostic and therapeutic procedures on his patients. Once a patient has been accepted, the fact that he cannot, or will not, pay the fee is not to interfere with the physician's commitment to treat. If the treatment is beyond the patient's means or offers the potential of great psychologic damage, the patient is to be informed and counseled. The patient is to be provided the opportunity of dying with dignity. This is the myth which physicians share with most of the general public—a fact of great importance.

This myth is in the process of breaking down. Organized medicine produced the first cracks by (1) securing the collusion of government to limit the supply of physicians; (2) encouraging the individual physician to keep his patients "in the dark" about details of their conditions and the rationale of his treatments; and (3) forming Blue Shield plans in the 1930's to make it easier for physicians to collect their fees.

It is the extension of "physician insurance" (with accompanying hospitalization insurance) to ever larger segments of the population which has proved to be the source of the most corrup-

tion in the medical profession. As long as the patient is directly and personally responsible for fees, there is no question about the physician's individual responsibility for the triad of patient concerns. But as soon as some "third party" assumes responsibility for payment, the responsibilities of the physician become diffuse. The physician's instinct to treat every disease is no longer held in check by the need to advise the patient of the costs of the proposed treatment or by the patient's disinclination to part with his money.

Economics teaches us that when the cost of goods or services approaches zero, demand approaches infinity. As the responsibilities for the cost of medical treatment passes to society (either through private insurance programs or the treasuries of the federal and state governments), available technology sets the only practical limit to the amount of the physiologic healing arts that should be (from the viewpoint of the physicians) applied to the individual. The physician no longer needs to inform and ask the patient, for it will cost the patient nothing; he can simply *tell* the patient what he is going to do. Not surprisingly, need has developed for a law to guarantee the right of the patient to "*informed consent*." We have given every physician the keys to state and federal treasuries and express surprise that some have taken advantage of the opportunity. It is a testimonial to the strength of the medical myth that so few physicians have done so, and that we are surprised that any do. Nevertheless, the solidly based triad of physiologic, psychologic, and economic effects is now becoming an unstable duad because only rarely is a patient directly responsible for any significant portion of the cost of his medical treatment.

In such unstable circumstances, it is all too easy for the physician to forget another element of the triad—the human dignity or psychologic health of the patient. Extension or loss of life are becoming the only criteria for measuring a physician's success or failure. In the process, the physician is becoming a mere technician. Patients are becoming subjects; cancer of the colon in a 79-year-old white male subject is a technical challenge, with surgical resection clearly indicated. Often the result is a six-week

extension of life, involuntary release of feces into a plastic bag, and a \$30,000 charge to the third party.

Now that the myth vessel for some physicians has cracked, with resulting wasting away of their professional self-image (at a rate approaching the increase in their incomes), the people's myth of the physicians is also cracking and the result is similar: an erosion of the public image of the physician. With medical treatment becoming a "right" with little or no direct personal cost, the patient and his relatives are becoming less critical prospectively but more critical retrospectively. No failure to diagnose any condition, no matter how early or how obscure, need go unpunished. Malpractice suits flourish. Little wonder that the number of diagnostic procedures ordered by physicians is increasing by more than 10% per year.

The corruption process does not stop there. After removing one of the three key responsibilities of the professional, society is contributing to further corruption by weakening the second responsibility (for the psychologic effects of treatment). In addition, outrage over the cost of insurance premiums (and taxes) stemming from the physician's exclusive application of the third responsibility is generating determination to control his "diagnostic and treatment excesses." We have a utilization review committee looking over the shoulder of every physician when he selects a regimen of treatment. Moreover, we have the proposed Carter amendments to force hospital administrators to frustrate the physicians' orders. Thus, we contaminate the sole remaining element of the triad of professional responsibilities—and the invitation to corruption is almost irresistible.

If we continue to offer unparalleled temptations to physicians, we must expect that even more of them will succumb. Eventually our only alternative will be to federalize the practice of medicine. If we do, we are not going to like the quality of the service any better than we like the costs.

There are extant models of the hierarchy of a physician's values when he is an employee of a third party. The so-called "diagnosis and treatment of mentally ill" patients in state mental in-

stitutions is an interesting example. (See Thomas Szasz's "Patriotic Poisoners," *The Humanist*, November/December 1976.) Or one might consider the clinics at a large short-term county or state general care hospital. (See Sanford Jacobs, "Critical Care," *The Wall Street Journal*, April 28, 1976.) One might observe the illustrious performance of the physicians at the local Veterans Administration hospital. The one thing all these examples have in common is that, in the interest hierarchy of the employee-physicians, the true interest of the patient is at best a weak third.

For all their imperfections, the selection and payment of the physician by the patient and the practice of medicine by the standards of the medical myth are still the best alternatives available. Of course one cannot ignore either the benefits or the costs of the new medical technology in life-threatening circumstances. Insurance of the major medical type, with the patient paying some portion of the cost right through the last dollar, should provide each of us with economic protection from a medical catastrophe. In addition, it would fulfill our social responsibilities to individuals confronted with a medical catastrophe. Most important, both patient and physician would once again be living according to a valid triad of concerns on which to base appropriate judgments.

No myth operates perfectly. The medical myth would be operating better if the supply

of physicians had not been artificially restricted by government fiat (at the insistence of organized medicine). It would be operating better without federal tax incentives for employees to demand and employers to provide "health insurance." It would be operating better if government did not provide first dollar "health insurance" to large segments of the population. (See A. F. Ehrbar, "A Radical Prescription for Medical Care," *Fortune*, February, 1977.)

The medical myth would be operating better if the medical profession did not make itself mysterious and if the public were better informed about good medical practice. It would be operating better if government spokesmen ceased confusing the public with such terms as "health care," "health insurance," and "health plans," for it is the individual who cares for his own health. A physician diagnoses and treats disease. (See Ivan Illich, *Medical Nemesis: The Expropriation of Health*, Pantheon, 1976.)

Are we as a society better off if, as our leaders in Washington advocate, we make medical diagnosis and treatment a right for all, or if we return it to the status of a privilege? Neither solution will be perfect. However, I would prefer to pick my own physician, have him treat me in my community hospital, and pay for the services with my after-tax dollars than to be at the mercy of employees of the same folks who brought me Amtrak, Vietnam, and the Postal Service.

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MERGING EXISTING PRACTICES— PRACTICAL CONSIDERATIONS

LEIF C. BECK, LL.B., CPBC
VASILIOS J. KALOGREDIS, J.D.

The increased popularity and success of group practice have caused many doctors to consider joining other doctors already in practice. Increasing numbers are in fact merging.

Why Merge?

While there may be a variety of circumstances involved, the following example illustrates some of the factors fueling the growing trend. Dr. X, 53 years old, and Dr. Y, 38 years old, are the only two urologists on the staff of a hospital in a growing suburban locale. Dr. X has been practicing in the area for nearly twenty years, Dr. Y for five years. The only urologists in the area, they have come to depend on each other for coverage on nights, weekends, and during vacations. Dr. X has reached the stage of his career where he is seeking more free time to spend with his growing family and he is looking ahead to retirement in ten or twelve years; Dr. Y, while younger, similarly feels the pressures of his busy practice and its demands upon his time and family.

After considerable soul searching, both physicians concluded that merger was the answer. They recognized the strong bond arising from their coverage needs. Each had seen many of the other's patients during hospital coverage; hence, each doctor understood well how the

other doctor practiced and thought. The doctors had some of the professional stimulation derived from intelligent discussions of medical cases and problems, often lacking by solo practitioners, but they sought even more and believed they could get it by working together even more closely. What is more, some of the higher billing expenses, office expenses, legal and accounting costs, and the like, of the separate practices seemed at least partially avoidable.

It also appeared that the doctors' practicing as one economic unit would provide some degree of income protection if one of them should be disabled because of illness or injury for any extended period. While great care has to be exercised to assure that such arrangements not penalize the "healthy" doctor, the concept of a continuing practice providing support is extremely important. The same can be true to a limited extent upon one doctor's death, retirement, or other required departure.

The example given above is one of the clearest cases in favor of merger, but so many others confirm the same basic feelings. For example, we think of four pediatricians coming together from separate practices for various coverage and peer communication reasons; three general surgeons to obtain coverage and improve their response to referrals; and several family practitioners for cost efficiency possibilities.

Messrs. Beck and Kalogredis are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd, Pennsylvania.

Practical Merger Considerations

Once agreement has been reached that the practices should merge, numerous practical matters must be faced. The following list is by no means all-inclusive, but it probably shows why we feel that the doctors *must* decide to meet at least once a week for at least three months to plan out all the steps and assure that their thinking is on a common wave length.

Professional Advice

There are many technical legal and tax matters involved, some of a subtle nature. Expert legal, accounting, and/or consulting assistance should be procured to assure that all is competently handled. We believe those advisors should do more than passively answer the doctors' questions, for the doctors may not know the right questions. The advisors should draft an extensive memo or checklist of all the details to be resolved, both technical and management-oriented. They should be able to recommend specifically on most of the items, drawing on specific prior experience as well as on technical tax, accounting, and legal rulings. Failure to obtain proper guidance on some of these items can have disastrous economic effects. For example, several practices can merge in a variety of ways to accomplish the same end result but with drastically different tax liabilities.

Income Division

The most important decision the doctors must make is how to divide income. If this question cannot be resolved, either the merger will never result, or a breakup arising out of conflict over income division will result shortly after the merger.

The most common ways of dividing income are equally, on the basis of production, or a combination of the two.

Without delving into the pros and cons of all alternatives (which would take a whole article), we cannot stress enough that to say simply, "we'll divide income equally" without reviewing the separate practices' respective financial histories could be a big mistake. For example, large disparities in the volume of practice, gross production, and/or net income may

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require income differences to fairly reflect that contributed to the joint practice. This points out the importance of complete openness among the physicians involved as to their respective practice financial matters so all will be treated fairly and honestly. Without such openness, the practice may be starting out on the wrong foot with possible overtones of mistrust.

After the numbers have been supplied and various alternatives have been described, the respective feelings of the physicians should be aired as to the equitable division for them. This is most important to insure the happiness of the group.

Pre-Merger Agreement

When the doctors have agreed in principle and are committed to the merger, they might enter into a signed pre-merger agreement. This can take various forms, but it basically protects each physician from another's unilaterally pulling out after a substantial financial and professional commitment has been made. While such an agreement can prove to be useful in almost any mer-

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ger situation, it is especially important when other financial and legal undertakings are involved (for example, a separate real estate partnership organized to borrow money, buy land, and build a new building).

Side Agreement

We would also recommend what we call a "side agreement" to serve two basic purposes. First, it would protect the "innocent" doctors and practices from pre-merger liabilities (malpractice, tax, etc.) of prior practices of which they were not a part. The "guilty" parties would either incur all liabilities personally or else indemnify those innocent of any wrong.

Second, if liability should be incurred by one or more physicians or practices as a result of activity directly relating to the merger (eg, a tax liability imposed upon a prior practice because of the merger), this agreement would provide that the new practice and all in it would share this burden since it would not have occurred were it not for the merger. The protection should include the expenses (such as legal and

accounting fees) of resisting any such claimed liabilities, since these could arise and be substantial even if there is finally found to be no actual liability at all.

New Office Space

A merger often results in the physical moving of both practices, since neither existing office may be large enough for the resultant practice. Thus, a variety of leasing, purchasing, and construction options should be investigated. A particular problem will arise if the newly desired space is not ready for occupancy by a reasonable merger date. We have concluded in such cases that it is preferable to start the joint practice on a selected date anyway, even if in the separate, old offices just to assure that the merger actually results before the doctors' enthusiasm should wane.

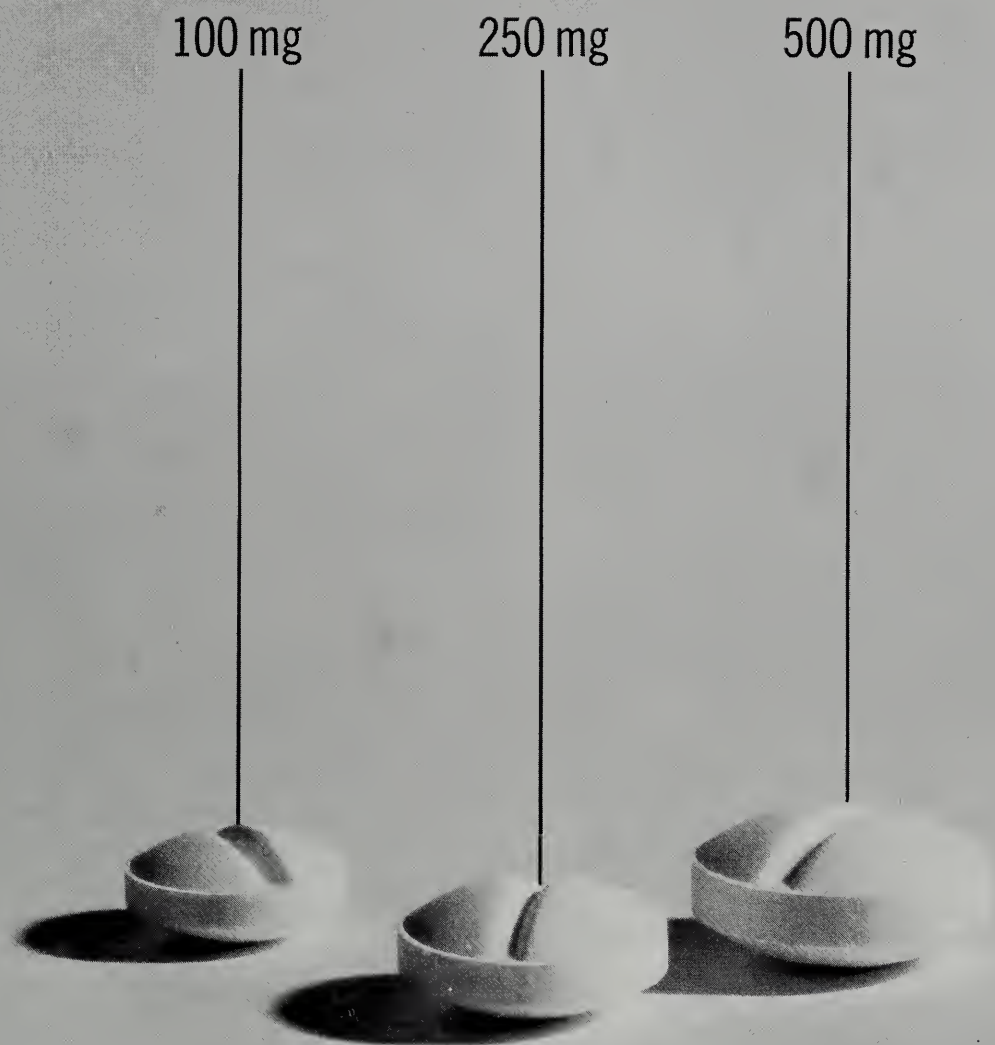
A common mistake that can prove very costly is to underestimate the new practice's space needs. It can result in a prematurely forced move. Unless adequate space is obtained, inefficiencies and stunted practice growth will be experienced.

Office Layout

If moving to a new office, the doctors will have an opportunity to assure that the space is laid out as efficiently as possible. Factors include how many doctors may have office hours at the same time, how many examining rooms each will need for maximum effective patient care, how many bookkeeping, typing, assisting, and other personnel will be needed, and so on. It is not just a matter of how *much* space is required, for a new practice together presents a unique opportunity to consider creatively how that space can be used for most useful traffic flow—by doctors, by ancillary help, and by patients.

Assets Retained and Purchased

The physicians involved should survey the existing practices and decide which equipment, furnishings, fixtures, and the like should be contributed to the new practice. The need to coordinate the interior design of the office could result in furniture purchases to replace older things that did not fit in.



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We have often found that the assets contributed by each of the merging practices are of approximately equal value and therefore do not result in one doctor contributing substantially more than the other; however, in those cases in which there is a material disparity in the contributions, such differences can be reflected by a higher capital account balance, equalizing contributions of cash or additional income from the practice equal to any such differences.

Personnel Matters

The physicians should promptly meet with the separate practice's present aides, both to inform them of the merger before rumors mislead them and to evaluate their future roles in the new office. The doctors should then discuss between them which aides should be kept and what positions each should hold. It is very important to have specific jobs for each aides, hence avoiding the all too simple result of people working together with overlapping or undefined responsibilities. Job descriptions for each aide *in writing* can help prevent such inefficiencies.

Salaries will also have to be evaluated to assure that the new offices' pay scales will not be disproportionate. Equating salaries has often been

a difficult merger problem especially if two aides performing the same functions with similar expertise have been receiving grossly different salaries. Perhaps one painful observation can be kept in mind from our experiences: out of a merger it is likely that at least one excellent aide (and possibly several of them) will resign. The condition should simply be accepted as a "cost" of merger and not as a sign of the new practice's inadequacies.

It is particularly helpful for a newly merged office to deliver a jointly drafted "office policy manual" to each retained aide at the time of merger. This can standardize and set forth in writing the new practice's policies as to vacations, sick leave rights, salary raises, work evaluation periods, and the like. Since these rules may have varied among the prior practices, the writing can help avoid employee embarrassments during the essential first year after merger.

Integrating Charts and Records

The physicians should avoid working from separate files and should instead develop a single new filing system. Since there should be several months' "lag time" before the actual merger, much of the chart and record integration can be consummated in advance. Whenever a patient comes to either office or is seen in the hospital, his old chart could be pulled and recast in the new system. Often, depending on the type of practice and the amount of "lag time," most of the active files can be so transformed with minimum disruption upon the actual joinder. If nothing is done until the merger, a disruptive situation could develop with files in various different sizes, styles, and reference systems being thrown together.

Merger is an appropriate time to review and select new filing ideas such as color coding and problem-oriented systems. Color coding is especially important in a larger, merged practice, in which files generally tend to grow faster than ever, since the color identification makes it easier to weed out older files as time goes on. Failure to be prepared for such growth can be troublesome two or three years later.

The physicians should also discuss and consider uniformity in the way chart notations are

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made (perhaps considering the "problem-oriented" system) to make it easier for the others in the group to deal with each other's patients.

Appointments and Scheduling

The physicians will have to decide quite a few months before the merger date how the new practice will schedule both office and hospital work. Which mornings and/or afternoons will each doctor have office appointments? Should more than one doctor have office hours at the same time? What should be the schedule for hospital rounds, consultations, and the like? Will all patients be patients of the practice, in what we often call a "true group" practice, or will each doctor see his own patients and his alone (except in emergencies or on night and weekend call)? These are important questions requiring much discussion and input to determine the proper result for a given practice and its physicians.

Appointments are often scheduled some months in advance. Therefore, these questions cannot be put off until merger. As soon as they are decided, a joint appointment book should be obtained so appointments can be correctly booked for a smooth practice start on the merger date. Besides the practicalities of making appointment plans, discussion of these matters is invaluable in helping the merging doctors assure they are on the same "wave length" as to practice philosophies.

Fee Schedule

The physicians should jointly review their respective fee schedules and determine the appropriate single schedule for the common practice. Starting with the merger date, all services should be billed under that common schedule. This is important, for some doctors have been embarrassed by patients treated by several physicians in the same group and charged a different fee for the same service. The common fee schedule avoids the problem and also facilitates the aides' handling of billing, insurance work, and the like.

Third Party Insurance

To prevent initial billing delays, an assignment account should be established with third

party insurers such as Blue Shield and Medicare at least a month before the merger. If one of the merging practices is already a group practice and is to be the "surviving" entity, a new assignment account may not be needed but the physicians joining in would have to be added to the account. Blue Shield's rules require notice of every doctor joining or leaving the organization's assignment account.

Opening an assignment account is not usually difficult. Usually a brief telephone call to or meeting with one's local Blue Shield Professional Relations Representative will accomplish it. A simple letter to the Blue Shield representative is required to notify of the addition of a doctor to an existing assignment account.

As an unexpected fringe benefit, a merger of practices will sometimes result in an increased fee profile for one or more of the newly merged physicians. In one recent situation a young internist joined a senior doctor who participated in Blue Shield and had a very low profile. When the two became partners and established a single profile for the assignment account, Blue Shield used the *higher of the profiles of the two participating physicians for each procedure*, substantially raising the older physician's profile. We are not suggesting this as an overriding reason for merging, but the merger of individuals' fees can be advantageous economically.

Billing and Bookkeeping Systems

The billing systems of the previously existing practices should also be conformed into one effective system for the successor single practice. The resulting system should provide for the keeping of patient accounts, recording of all office and hospital work, keeping track of daily receipts, and sending out of bills and insurance forms. Without a good single system, there could be confusion, wasted time, and lost money.

We believe that the system should indicate how much of the charges are "produced" by each doctor, whether or not income is to be divided on the basis of productivity. Especially among new partners from diverse practices, we feel information about their relative work is vital to help them evaluate their new relationship. Lack of such clear statistical information usually will

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cause one or more of the doctors either to keep his own record (possibly less accurately) or to "imagine" the comparisons without a sound basis.

The bookkeeping system should be carefully reviewed with the person chosen to be the new group's accountant. The system he develops must create adequate controls over the handling of cash in the office, for a larger practice may have a much larger cash flow to be protected. We also strongly recommend that monthly statements be prepared either by a competent bookkeeper employee or by the accountant and presented to the doctors for review by perhaps the fifteenth of the following month. Such monthly statements are extremely important in well-run practices, especially to new groups where careful attention during the first few months can help the doctors set the practice's direction.

Collection Systems

Consideration should also be given as to the procedures to be followed in pursuing delinquent accounts so a uniform, effective policy can be

established. This should be dealt with before the merger, since our experience shows that such matters tend to be ignored once the joint operation begins—until serious problems have arisen and it has already become too late to properly handle many accounts.

Office Manager

Depending on the size of the resulting practice, it may be advisable to have an office manager to be responsible for some or all aspects of personnel administration, business systems, and the like. Selection of a key aide from one of the preexisting practices is one possibility, although it might present more problems than it solves if all other aides' personalities and egos might be bruised. As an alternative, an outside person might be hired to fill this special role, such person either being a full-time manager without normal aide duties or a new "super-aide."

Notices to Patients and Physicians

A notice should be jointly drafted and sent to patients, physicians, and others informing them of the new group practice. This notice might, within ethical restrictions on advertising, include some statement of group philosophy as a reason for joining together. Notifications suggesting that the new venture will be advantageous to the patients and referring physicians (eg, since a physician will always be available if they call this office) may help overcome natural reservations whether things will change for the worse.

In the same respect, the receptionists in each premerger office should be trained how to respond to various questions or objections raised by telephone callers. The news of a practice change can be disquieting to faithful patients, but planned handling can smooth the way.

Patient Information Booklet

The time of merger is the ideal time by which to have completed and printed a "Patient Information Booklet." Such a pamphlet can include a statement of billing and collection policies, handling of third party insurance forms, and other financial rules. It could also include common instructions to patients to reduce physician and aide time in repeating them so often (eg, questions commonly asked in examining

rooms, routine instructions, hospital admission procedures, and the like). Such a booklet could then be handed to each patient upon his first visit to the office after the merger, thus giving the new practice a stamp of new vitality with well-thought-out systems.

Technical and Legal Considerations

An in-depth analysis of the legal and technical considerations of a merger is beyond the scope of this article. We cannot stress enough, however, that competent professional advice is a necessity since subtle and complex tax questions hide behind any merger.

Among the legal and technical matters to be dealt with is a decision as to the form of the merger. For example, should a new professional corporation be established, or should one of the predecessors remain? How can an unincorporated predecessor best be merged into a professional corporation (or vice versa)? If not handled properly, the tax consequences could be disastrous.

If a corporation is to be the resulting entity, a variety of matters such as selection of a fiscal year, amending of articles of incorporation and by-laws, drafting of new stock purchase agreements and employment agreements must also be faced. And each physician must be assured of fair and equitable treatment from both the pre-merger and post-merger pension, profit-sharing, medical reimbursement, and other fringe benefit plans.

Conclusion

Group practice has both pros and cons, but if it is to be entered by merger of existing practices, it must be handled with extreme care. As we hope this article has shown, that handling must include competent and experienced outside advice, honest dealings between the doctors themselves, and a considerable amount of their time and attention. Given these ingredients, the newly merged practice should have its best opportunity to serve the doctors and their patients well for many years.

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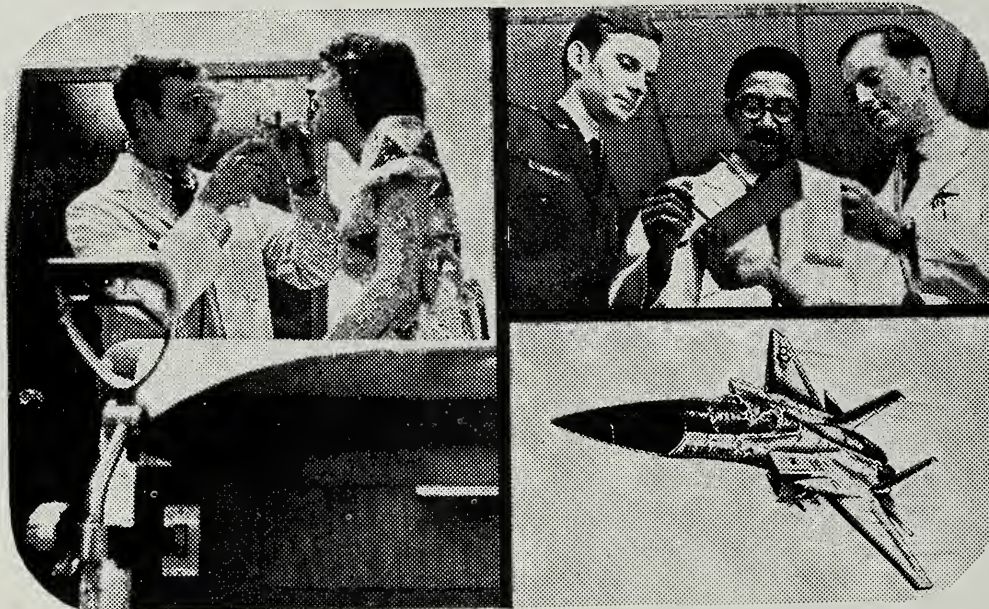
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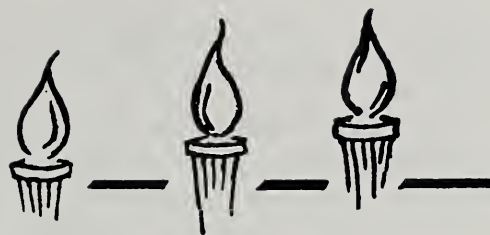
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THROMBOEMBOLISM IN ORTHOPEDIC SURGERY

VINCENT DELDUCA, JR., M.D., *Senior Attending in Medicine and Pathology, Wilmington Medical Center, Wilmington, Delaware. Adapted from a presentation to the Orthopedic Service, Wilmington Medical Center, May 30, 1978.*

The very high incidence of deep vein thrombosis and pulmonary embolism following emergency and elective orthopedic surgery of the lower extremities has been amply demonstrated by newer diagnostic techniques. Pulmonary embolism is the most common fatal complication following surgery or trauma to the lower extremities.

The clinical diagnosis of deep vein thrombosis and pulmonary embolism is difficult. Venography,¹²⁵ I-fibrinogen uptake testing, and non-invasive techniques to measure venous outflow obstruction have refined the diagnosis of the former, and arterial blood gases, pulmonary ventilation/perfusion scans, and pulmonary angiography the latter.

Effective prevention of deep vein thrombosis and pulmonary embolism is difficult and associated in some cases with the undesirable side effect of significant bleeding. Subcutaneous heparin, which is clearly efficacious in reducing the thromboembolic complications following thoracic and abdominal surgery, has been disappointing following hip surgery.¹ The use of coumarin drugs, first demonstrated in 1959 to prevent clinical and pathologic thromboembolism after hip fracture,² remains the most effective method, but unfortunately carries a 10-20% risk of bleeding. Dextran, which has been less well studied, may be equally effective but also can cause bleeding and has a small risk of severe allergic reactions, congestive heart failure, and

renal failure.³ Recently aspirin has been shown to protect men, but surprisingly not women after total hip replacement. This study excluded those with previous thromboembolism or venous surgery in order to enable easier interpretation of the venograms.⁴ Whether aspirin would also be effective in these latter high-risk groups is unknown.

It is thus clear that the ideal prophylactic method or agent is not yet at hand. Risk factors include age over 40, immobilization, history of previous thromboembolism or vein surgery, malignant disease, and obesity.⁵ In patients with high risk, coumarin drugs, despite their occasional associated bleeding, are probably indicated. In those at low risk, aspirin alone may be beneficial. One must be cautious in extending conclusions from one clinical situation (eg, total hip replacement) to another (eg, elective knee surgery); much more information is needed.

Despite extensive clinical investigation, thromboembolism remains a difficult challenge for the orthopedic surgeon.

REFERENCES

1. Thomas DP: Heparin in the prophylaxis and treatment of venous thromboembolism. *Seminars in Hematology* 15:1, 1978.
2. Sevitt S, Gallagher NG: Prevention of venous thrombosis and pulmonary embolism in injured patients. *Lancet* 2:981, 1959.
3. Harris WH, Salzman EW, Athanasoulis CA, et al: J Bone and Joint Surg 56:1552, 1974.
4. Harris WH, Salzman EW, Athanasoulis CA, et al: Aspirin prophylaxis of venous thromboembolism after total hip replacement. *NEJM* 297:1246, 1977.
5. Kakkar VV, Howe CT, Nicholaides AN, et al: Deep vein thrombosis of the leg: is there a high risk group? *Am J Surg* 120:527, 1970.



VESICoureTERAL REFLUX—AN UPDATE

WILLIAM J. CROMIE, M.D., *Assistant Surgeon in Urology, Children's Hospital of Philadelphia, and Associate Professor of Urology, University of Pennsylvania. This paper was adapted from a*

Highlights

presentation to the Department of Pediatrics, Wilmington Medical Center.

Vesicoureteral reflux due to an anatomical abnormality of the submucosal ureteral tunnel is more frequently associated with urinary tract infections than might be expected. Forty to sixty percent of children under one year of age with a urinary tract infection will have associated vesicoureteral reflux of some degree. This population is at a greater risk because of the increased vulnerability of the renal parenchyma to bacterial insult. Recent evidence indicates that the configuration of the renal papillae as well as the degree of severity of reflux has a strong bearing on the occurrence of pyelonephritic changes in the pediatric age group.

In the child presenting with fever, symptoms of pyelonephritis, and a positive urine culture, an IVP and voiding cystourethrogram are mandatory regardless of sex. If possible, these studies should be performed while the patient is awake, simulating a normal voiding sequence in the child.

For classification purposes, reflux has been graded from I to IV, grade I being the least severe and grade IV being manifested by severe ureteral dilatation and calyceal blunting. Once reflux is detected, regardless of the degree of severity, the child should be placed on chronic suppressive medication to prevent recurrent lower urinary tract infections as well as acute pyelonephritis.

In children with less severe degrees of vesi-

coureteral reflux, there is a forty to fifty percent chance of spontaneous cessation of reflux with progressive age. This non-surgical approach requires meticulous observation, however, including maintenance of a sterile urine and assurance of continued renal growth.

Patients with more severe degrees of reflux may be managed temporarily by antimicrobial suppression but will often require ureteral reimplantation to preserve renal function and to prevent infection. Our basic guidelines for performing reimplantations include: urinary tract infections that cannot be controlled medically; evidence of pyelonephritic scarring or arrested renal growth; severe reflux, especially with renal scarring; and any anatomical change in the ureterovesical junction such as a diverticulum, a gaping ureteral orifice, or a short submucosal tunnel, which would make spontaneous cessation of reflux unlikely.

In the hands of an experienced surgeon, a ninety percent success rate can be anticipated. Following successful surgery, daily medication to suppress infection can be discontinued, but the child should be followed closely as he then has the same susceptibility to lower urinary tract infections as all other children his age.

Because in large part of the vigilance of our pediatric colleagues, we are able to pursue our goals in the management of vesicoureteral reflux; namely, early detection, normal renal growth, and the prevention of pyelonephritic scarring and subsequent hypertension.



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Editorials

THE SI UNIT REVISITED

A June 1975 editorial in this *Journal* commented on the introduction of the SI unit* into clinical measurements and the confusion which would almost certainly result.¹ Since then, virtually no progress has been made in the implementation of SI in the USA. In May 1977, however, the World Health Organization (WHO) recommended the general adoption of the SI unit in medicine, following a trend which has been developing in a number of countries over the years.²

The international system, as it is called in English-speaking countries, is already well established in much of Western Europe and in Australia, New Zealand, and South Africa; even Canada has shown signs of weakening.³

Why, then, has there been such a reluctance to introduce the change in the United States? There are probably many reasons for this less-than-eager approach to a system that is uniform, supposedly coherent, and potentially world wide. Forecasts of clinical disasters made in the correspondence columns of the *British Medical Journal* and *Lancet* when SI was introduced in Britain in 1974-75 proved to be largely unfounded. A comparison made between these letters and those written in 1953 following the introduction of the milliequivalent shows a rather depressing similarity.⁴ One criticism that has been made is that the mole is not a basic SI unit, and already compromises have been in some areas: eg, proteins may still be reported in mass rather than quantity units.

The mole was introduced because chemical substances react on a molar rather than mass basis, but the improved relevance of using molar units is far from clear to most people and unless

there are clearly perceived advantages, SI is unlikely to gain ground. A better understanding of physiologic mechanisms can be gained by using molar concentrations.⁵ All physicians know that unconjugated bilirubin circulates in the blood bound to albumin; they also know that a bilirubin concentration of 20 mg/dl is considered critical in the potential development of kernicterus in the newborn. How does 20 mg/dl bilirubin relate to 4.0 g/dl albumin? It would appear that there is plenty of albumin around to bind bilirubin. Conversion of these values to molar concentrations shows the critical relationship far more clearly, for at the levels quoted the bilirubin concentration is 340 $\mu\text{mol/l}$ and albumin 580 $\mu\text{mol/l}$. Currently we measure calcium and magnesium in mg/dl; this does not help in understanding the contribution of these ions to the ionic balance of plasma. Similarly, the part played by ethanol in the development of hyperosmolality is better appreciated when it is realized that 300 mg/dl ethanol translates to 65 mmole/l.

The above examples of the advantages of the new system, while real, may seem small when viewed against the seemingly overwhelming problem of learning new units and new reference values; however, it has already been shown in many countries that the transition need not be too traumatic. It is important that this change be implemented here soon; otherwise the United States will stand alone, unable to decipher laboratory values in foreign medical journals, while our own journals will become increasingly difficult to interpret abroad.

P.J.P.

REFERENCES

1. Editorial, The SI—More Bad News?, *Delaware Medical Journal*, June 1975.
2. World Health Organization: The SI for the Health Professions, Geneva WHO, 1977.
3. Karnauchow PN, Suvanto L: Experience with SI units in biochemistry. *Can Med Assn J* 114:533-536, 1976.
4. Pannal PR: Letter to the Editor. *Brit Med J* 1:583, 1976.
5. Young DS: Standardized reporting of laboratory data. *NEJM* 290:368-373, 1974.

*Under the SI (for Systeme International d'Unites) substances measured in blood are no longer reported in terms of mass; ie, weight per volume (example: gm/dl). Instead numerical reports are related to the amount of substance (mole) per unit volume (liter). Generally speaking a mole of any substance is its molecular weight in grams.

HEALTH LEGISLATION OF INTEREST TO MEDICAL SOCIETY OF DELAWARE

A bill introduced in the General Assembly must pass both houses of the Legislature in the same form before it goes to the Governor for signature. Unenacted bills will remain alive for the second session.

Most legislation dealing with health and medical care is assigned to either the Senate Committee on Health and Social Services, chaired by Senator Herman M. Holloway or the House Committee on Health and Social Services, chaired by Representative Robert F. Gilligan.

The second session of the 129th General Assembly has completed its work. The following is a listing of some of the legislation with significance for medicine that was considered by this General Assembly.

Allston J. Morris, M.D. is Chairman of the Public Laws Committee, which considers health legislation and makes recommendations to the Board of Trustees of the Medical Society of Delaware. For further information or a copy of any of the bills listed contact the Society office, 658-7596.

BILL	TITLE - SUBJECT	SOCIETY POSITION	CURRENT STATUS
H.B. 2	Relating to the Public Health and Welfare; And Providing for Cessation of Medical Care for Terminal Patients (Ridings)	Prefer adoption of guidelines for care of comatose, non-cognitive patients	Still in House Health and Social Services Committee
S.B. 11	Relating to the Eligibility of Chiropractic Physicians for Compensation from Insurance, Group Hospital Services and Related Plans; And Further Providing Medical Care to the Indigent and Medically Indigent (Murphy)	Opposed	Passed Senate; in House Judiciary Committee since 5/18/77
S.B. 23	Providing for the Division of the Department of Health and Social Services into Two Separate Departments (Holloway)	Supported	Reported out of committee in Senate; has not passed either house
H.B. 271	Relating to Operating or Riding on Motorcycles (Byrd)	Strongly opposed	Signed by Governor 6/10/78
H.B. 283	Relating to Medicine, Surgery, and Osteopathy; And Providing for an Infant Protection Act (Ambrosino, Conner, Gilligan, Rispoli, Jonkier et al)	Opposed; supported guidelines established by the Wilmington Medical Center and the obstetricians	Still in committee
H.B. 303	Relating to the Custody, Care and Treatment of Delinquent, Neglected and Dependent Children (Worthen, Hebner)	Supported	Signed by Governor 6/20/78

S.B. 329	Providing for the Establishment of a Health Services Cost Review Commission within the Department of Health and Social Services to Be Appointed by the Governor (Murphy)	Opposed	Still in Senate Health and Social Services Committee
S.B. 387	Relating to the Naming of Professional Service Corporations (Zimmerman)	Supported	Signed by Governor 6/27/78
S.B. 472	Relating to the Establishment of a Division for the Visually Impaired under the Department of HASS (Holloway)	Opposed the bill but favored the intent of emphasizing needs of visually impaired	Signed by Governor 6/19/78
S.B. 505	Prohibiting Reckless Conduct and to Further Protect Children under Twelve from Access to Materials Harmful to Minors (Kearns)	Supported	Passed Senate; was not voted on in House
S.B. 528	Relating to Nuclear Power Plants; and Providing for a Moratorium on Any Further Construction Until Certain Conditions Are Met (McDowell)	Opposed	Still in Senate Energy Committee
H.B. 529	Making an Appropriation to the Delaware Technical and Community College for a Nuclear Medicine Program (Ferguson, Gilligan)	Supported	Signed by Governor 4/7/78
H.B. 563	Relating to Hospitals and Other Health Facilities; and Providing for a Rate Review Program (Ambrosino)	Opposed	Still in House Health and Social Services Committee
S.S. 1 for S.B. 580	Relating to Unit Support of Handicapped Children and Further Making a Supplementary Appropriation Therefor (Holloway)	Supported	Passed Senate; was not voted on in House
S.B. 581	Relating to Psychologists and Speech and Hearing Teachers in Public Schools (Holloway)	Supported	Did not come to a vote in either House

BILL	TITLE - SUBJECT	SOCIETY POSITION	CURRENT STATUS
S. B. 589	Making a Supplementary Appropriation to the Department of Health and Social Services, Division of Public Health, for the Purpose of Continuing the Operation of the Preschool Diagnostic and Development Nursery in Kent County (Zimmerman, Berndt, Murphy et al)	Supported	Passed Senate; was not voted on in House
S.B. 655	Substituting an Entirely New Chapter Entitled "Voluntary and Involuntary Sterilization" and Making an Appropriation Therefor (Holloway, Berndt)	Supported	Passed Senate 6/28/78; in House Judiciary Committee
S.B. 667	To Exempt Medical Personnel Working under the Supervision of a Doctor of Medicine, Doctor of Osteopathy, or Optometrist from the Provisions of Chapter 21, Title 24 (Optometric Practice Act) (Cordrey)	Opposed	Did not come to a vote in either house
S.B. 693	Relating to Pharmacy (Fining Pharmacists Who Refuse to Fill Medicinal Prescriptions) (Holloway)	Opposed	Did not come to a vote in either house
H.B. 696	Providing for a Certificate of Need Regarding Equitable Health Planning and Review for the Development, Acquisition, Construction, Expansion and Modification of Health Facilities and Services in This State (Gilligan)	Opposed to CON legislation	Stricken
H.B. 699	Relating to the Free Public Schools; and Providing for the Employment of Practical Nurses (Ambrosino)	Opposed	Still in House Education Committee
H.B. 703	Creating a Commission on Hospitals and Health Care and Making an Appropriation Therefor (Jonkier, Maxwell, McDowell, Murphy)	Opposed	Tabled in the House

H.B. 718	Relating to Day Care Regulations (Worthen, Minner)	Supported	Tabled in the House
H.B. 784	Relating to the Expenditure of Public Funds in the Purchase of Drugs (Ferguson)	Strongly opposed	Tabled in the House
H.B. 803	Relating to Expert Witnesses in Health Care Malpractice Insurance and Litigation (Ambrosino)	Opposed	Still in House Banking and Insurance Committee
H.B. 841	Relating to the Rights of Patients in Sanatoria, Rest Homes, Nursing Homes, Boarding Homes and Related State Institutions (Kelly, Jonkier, Cicione, Sharp)	Did not oppose	Signed by Governor 6/28/78
H.B. 868	Relating to Hospitals and Providing Certain Licensing Requirements (Ambrosino)	Opposed	Tabled in the House
H.B. 890	Relating to the Good Samaritan Act (Clendaniel)	Supported in principle; wanted paramedics added	Tabled in the House
H.B. 956	Relating to Hospitals and Other Health Facilities; and Providing a System of Health Planning and Review (Certificate of Need) (Gilligan)	Supported H.A. 2, which eliminated physicians' offices from consideration	Signed by Governor 6/30/78 (with H.A. 2)
H.B. 1007	Providing a Unit and Staff Authori- zation for the Handicapped Pupils Who Are Deaf-Blind (Maxwell)	Supported	Signed by Governor 7/11/78
H.B. 1033	Relating to Mental Health; and Pro- viding for the Expungement or Nullification of Certain Records (Ambrosino)	Supported	Still in House Health and Social Services Committee

Book Reviews

INFECTIOUS DISEASES, 2nd ed., edited by **Paul D. Hoeprich, M.D.**, Harper & Row Publishers, Inc., Hagerstown, Maryland, 1977. 1258 pp. Illus. Price \$42.50.

The first edition of Hoeprich's textbook on infectious diseases was well-received as a standard reference in this important field of medicine. While that textbook had the obvious shortcoming of a multi-authored text, it became popular with medical students, primary physicians, and specialists in the field of infectious disease. Every medical discipline has a prototype major reference volume.

The second edition, released in late 1977, is a significant improvement over its predecessor and should receive even greater acceptance than the first edition.

A total of 97 experts has contributed chapters to this volume, including new material on previously uncovered subjects and major rewrites by new authors of material included in the first edition.

As is expected in an undertaking of this magnitude, there is considerable variation in the quality of the material presented by numerous authors; however, even the less well-written chapters serve the purpose of providing rapid orientation to an infectious disease for the clinician presented with a diagnostic or therapeutic problem.

While the editor should be congratulated for the completeness with which the field of infectious disease is covered, some of the chapters are so scanty that one questions the decision to include them in the monograph. For example, Chapter 151 on "Infections Following Surgical Operations" is so brief and vague that I think it would be better left out of the publication.

One other major objection to this volume is the inadequate bibliography associated with many chapters. In some instances, the bibliography appears to omit many, if not all, of the important references to the subject at hand, and, unfortunately, none of the text is referenced to the bibliography.

These deficiencies are completely outweighed by the outstanding contributions to the medical literature on infectious disease offered by many of the authors. Particularly outstanding are Hoeprich's chapters on pneumonia and the manifestations of infectious diseases. Other exceptional contributions include the sections on fungus infection by Utz, Finegold's contributions on anaerobic infections, and Hornick's chapters on infections of the intestinal tract.

If one considers the size of this volume and current publishing prices, the sales price of \$42.50 is reasonable. Primary physicians who are willing to spend that amount should at least be certain that this reference book is available in a convenient library. The practice of medicine will be just a little easier if Hoeprich's textbook is close at hand.

WILLIAM J. HOLLOWAY, M.D.

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HYPERTENSION: A POLICY PERSPECTIVE by **Milton C. Weinstein, William B. Stason, M.D.**, Harvard University Press, Cambridge, Massachusetts, 1976. 243 pp. Illus. Price \$15.00.

Milton Weinstein is a faculty member of the John F. Kennedy School of Government at Harvard, experienced in the use of quantitative methods in public decision making. William Stason, an internist and cardiologist, is on the faculty of the Harvard School of Public Health. They have married their talents to produce a quantitative analytical approach to the management of hypertension. It is an interesting concept and obviously the product of much research.

The scope of the book is such that it will appeal to only a select group of readers, ie, those people involved in or otherwise interested in developing public policy for hypertension management. The book would not be of reading interest to most general internists, family physicians, or cardiologists.

The text is heavily laden with quantitative analytical equations and in-depth discussion for the rationale involved with the many factors entering in these equations. Unless one is especially motivated or interested in quantitative analysis, the reading becomes tedious in places.

The authors have addressed themselves to an important public health problem and analyzed it in terms of cost effectiveness in our health care system. The policy decision makers should pay attention to their work. It is a more detailed and complicated discussion than most health care providers in this area would be interested in reading.

JAMES ANTHONY TRUAX, M.D.

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1977 YEAR BOOK OF FAMILY PRACTICE edited by Robert E. Rakel, M.D., Year Book Medical Publishers, Chicago, 1977. 438 pp. Price \$23.95.

Year books must be a successful publishing venture since the Year Book Medical Publishers, Inc. produce them annually in 22 different varieties. Personally, I am never quite sure how to use them. They are much too concentrated to read through. They do make good browsing, and if one suddenly decides he must catch up on a whole year's worth of relevant literature all at once, this is the way.

The abstracts seem all to have been expertly done by persons who truly understood the material, which makes them, on the whole, easy to

read. Clever editorial comments are the usual practice in this series.

VARIETIES OF SEXUAL EXPERIENCE by Norman Kiell, International Universities Press, Inc., New York, 1976. 753 pp. Price \$42.50.

Kiell has done an amazing job at ferreting out the latent sexuality in things we have all read but never realized were so sexy (like Huck Finn and Moby Dick) as well as defining the various types of more explicit sexuality in the works of obviously erotic authors like James Joyce, Norman Mailer, and anyone else you can name.

The varieties of sexual experience demonstrated range from the Primal Scene through Olfactory Eroticism, past Group Sex to Narcotics and Sex, the 15th and last chapter. More than 150 authors are excerpted; the excerpts are all long enough to enjoy.

Even if you do not always agree with Kiell—by that I mean, if you cannot see sex where he does—the range of his reading and his imaginative analyses are very interesting. This is a good browsing book especially for devotees of fiction, and also a good gift for the right sort of person.

BERNADINE Z. PAULSHOCK, M.D.

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In Brief

Speakers on "Ask the Doctor"

Speakers for September on the Tuesday radio program (11:05 a.m., WDEL), produced by the Medical Society of Delaware are: September 5, *Jeffry I. Komins, M.D.*, The Risks of Home Delivery; September 12, *John T. Hogan, M.D.*, Degenerative Arthritis of the Hip; September 19, *James M. Hofford, M.D.*, Lung Diseases; September 26, *Richard A. Kahlbaugh, M.D.*, Pneumonia.

Educational Material from ACS

The following professional education material is available through the American Cancer Society: 1) The Physician's Role in the Control of Lung Cancer—film; 2) "I Quit Kit" for smokers; 3) ACS/NCI Proceedings of the 1976 National Conference on Cancer Research and Clinical Investigations; 4) Leukemias and Lymphomas: Statistical and Epidemiological Information; and 5) Meeting highlights, ACS/NCI 1977 National Conference on the Lymphomas and Leukemias, held in New York City. For information contact: Ms. Marisol Douthit, ACS, 654-6267.

Teleconference Series for Clinical Labs

A continuing education program of the Center for Disease Control (CDC) in cooperation with the University of Delaware and State of Delaware, Division of Public Health, will be held alternate Thursdays through December, 1978. The locations are varied, and registrants will be advised of exact locations at the time of registration. Presentations consist of telephone lectures (conducted by scientists and doctors from the CDC) of approximately 30 minutes, accompanied by hand-out notes and color slides. At the end of the lecture the program is open for a two-way question and answer session with CDC staff in Atlanta. Through special "party-line" conference equipment all participants and locations are in live two-way communication with each other. Each individual program in the series is valued at 0.8 continuing education units. The fee for each program is \$15/person. For information contact: Richard Gearhart, Division of Continuing Education, University of Delaware, Newark, Delaware 19711. (302) 738-1171.

SEPTEMBER 14 — THE HISTOPATHOLOGY OF LEGIONNAIRES' DISEASE

SEPTEMBER 28 — FUNDAMENTAL NATURE OF THE ANTIGEN-ANTIBODY SYSTEM

OCTOBER 12 — IDENTIFICATION OF INTESTINAL PROTOZOA, PART I
AMEBAE IN STAINED FECAL PREPARATIONS

OCTOBER 26 — IDENTIFICATION OF INTESTINAL PROTOZOA, PART II
AMEBAE AND FLAGELLATES IN WET MOUNTS

NOVEMBER 9 — EVALUATION OF FIA KITS

DECEMBER 7 — PRESUMPTIVE IDENTIFICATION OF ANAEROBIC
NONSPOREFORMING GRAM-NEGATIVE BACILLI

CLINICAL NOTICES AND MEETINGS

**Cardiology
Conference**

The American Heart Association, with various co-sponsors, will present AN APPROACH TO PROBLEMS IN CARDIOLOGY-1978 FOR THE PHYSICIAN IN PRACTICE, October 25-27, Greenbrier Hotel, White Sulphur Springs, West Virginia. The program meets the criteria for 15 hours in Category I of the AMA Physician's Recognition Award and 15 elective hours by the American Academy of Family Physicians. Pre-registration is requested by August 15. For information contact: American Heart Association, 8320 Greenville Avenue, Dallas, Texas 75231. Attention: Scientific Session.

**Scientific
Assembly**

The 63rd ANNUAL INTERNATIONAL SCIENTIFIC ASSEMBLY OF THE INTERSTATE POST-GRADUATE MEDICAL ASSOCIATION OF NORTH AMERICA will be held October 23-26, in Washington, D.C. It provides 24 hours of prescribed credits for members of the American Academy of Family Physicians. Also credit toward the AMA Physician's Recognition Award is provided through attendance. For information contact: Alton Ochsner, M.D., Program Chairman, Interstate Postgraduate Medical Association, P.O. Box 1109, Madison, Wisconsin 53701.

ACP Courses

The American College of Physicians will present the following postgraduate courses, which fulfill Category I credits for the AMA Physician's Recognition Award.

MONTANA/WYOMING REGIONAL MEETING, September 8-9, Jackson Lake Lodge, Moran, Wyoming. For information contact: Francis J. Allaire, FACP, 1220 Central Avenue, Great Falls, Montana 54901.

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NEW HORIZONS IN RHEUMATIC DISEASES, September 11-13, Mayo Clinic, Rochester, Minnesota. For information contact: Registrar, ACP, 4200 Pine Street, Philadelphia, Pennsylvania 19104. (215) 243-1200.

WISCONSIN REGIONAL MEETING, September 14-15, Fox Hill Country Club, Mishicot, Wisconsin. For information contact: Charles L. Junkerman, FACP, 831 N. 66th Street, Wauwasota, Wisconsin 53213.

SOUTH DAKOTA REGIONAL MEETING, September 15-16, Rapid City, South Dakota. For information contact: Everett W. Sanderson, FACP, 1320 S. Minnesota Avenue, Sioux Falls, South Dakota 57105.

OHIO REGIONAL MEETING, September 15-16, Columbus, Ohio. For information contact: Richard P. Lewis, Room 669, Means Hall, 466 W. 10th Avenue, Columbus, Ohio 43210.

MULTIDISCIPLINARY MANAGEMENT OF SOLID TUMORS, September 18-20, Mayo Clinic, Rochester, Minnesota. For information contact: Registrar, ACP, 4200 Pine Street, Philadelphia, Pennsylvania 19104. (215) 243-1200.

RENAL, ELECTROLYTE, AND HYPERTENSIVE DISORDERS—FOR THE CLINICIAN, September 25-27, Four Seasons Hotel, Vancouver, British Columbia. For information contact: Registrar, ACP, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

CARDIOVASCULAR ECHOCARDIOGRAPHY, October 4-6, Baylor College of Medicine, Houston, Texas. For information contact: Registrar, ACP, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

MEXICO REGIONAL MEETING, October 5-6. For information contact: Luis R. Velasco-Candano, Londres 139 Coyoacan, Mexico 21, DF Mexico.

ONTARIO REGIONAL MEETING, October 5-6, Holiday Inn-City Center Tower, London, Ontario. For information contact: Ramsay W. Gunton, FACP, University Hospital, 339 Windemere Road, London, Ontario N6A 5A5, Canada.

ARIZONA REGIONAL MEETING, October 6-7, Registry Resort Hotel, Scottsdale, Arizona. For information contact: Charles A. L. Stephens, Jr., FACP, 5100 East Grant Road, Tucson, Arizona 85712.

EASTERN PENNSYLVANIA REGIONAL MEETING, October 6-8, Pocono Hershey Hotel, White Haven, Pennsylvania. For information contact: George L. Jackson, FACP, Harrisburg Hospital, S. Front Street, Harrisburg, Pennsylvania 17101.

FOUR STATE REGIONAL MEETING (Delaware, Maryland, Virginia, Metropolitan DC), October 6-8, Williamsburg, Virginia. For information contact: Frank G. MacMurray, FACP, 3301 New Mexico Avenue, N.W., Washington, D.C. 20016.

MICHIGAN REGIONAL MEETING, October 6-8, Otsego Ski Club, Gaylord, Michigan. For information contact: Boy Frame, 543 Lakepointe, Grosse Pointe Park, Michigan 48230.

UPSTATE NEW YORK REGIONAL MEETING, October 12-13, Americana Inn, Albany, New York. For information contact: William J. Williams, FACP, Department of Medicine, State University Hospital, 750 E. Adams Street, Syracuse, New York 13210.

NEW ENGLAND REGIONAL MEETING, October 13-14, Ramada Inn, Portland, Maine. For information contact: Harry A. Bliss, FACP, 128 Chadwick Street, Portland, Maine 04102.

KENTUCKY REGIONAL MEETING, October 14, Hyatt-Regency, Lexington, Kentucky. For information contact: Walter S. Coe, FACP, 207 Baptist E. Doctors Building, Louisville, Kentucky 40207.

FLORIDA REGIONAL MEETING, October 13-15, Breakers Hotel, Palm Beach, Florida. For information contact: Charles K. Donegan, FACP, 501-11th Street N, St. Petersburg, Florida 33705.

SELECTED TOPICS IN INTERNAL MEDICINE, October 18-20, McMaster University Medical Centre, Hamilton, Ontario. For information contact: Registrar, ACP, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

PUERTO RICO REGIONAL MEETING, October 20-21, Dorado Beach Hotel, Dorado, Puerto Rico. For information contact: Jose M. Torres-Gomez, FACP, P.O. Box 2384, San Juan, Puerto Rico 00903.

CLINICAL SPECTRUM OF ADULT HEART DISEASE, October 26-28, University of New Mexico School of Medicine, Albuquerque, New Mexico. For information contact: Registrar, ACP, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

ACS Clinical Congress

The American College of Surgeons will hold the 64th **ANNUAL CLINICAL CONGRESS**, October 16-20, San Francisco, California. For information contact: Ms. Ginny Clark, Public Information Assistant, ACS, 55 East Erie Street, Chicago, Illinois 60611. (312) 664-4050.

AAP Annual Meeting

The American Academy of Pediatrics (AAP) will hold its **ANNUAL MEETING**, October 21-26, Palmer House Hotel, Chicago, Illinois. A special scientific session on "Controversies in Pediatrics" will be among the presentations. The meeting is accredited for a maximum of 33 credit hours in Category I of the AMA Physician's Recognition Award. Pre-registration is required. For information contact: AAP, P.O. Box 1034, Division M, Evanston, Illinois 60204.

Abdominal Laparoscopy Course

The Delaware Valley Society for Gastrointestinal Endoscopy is sponsoring a Category I, 4½ credit-hour course, **ABDOMINAL LAPAROSCOPY IN DIAGNOSIS AND MANAGEMENT OF ABDOMINAL DISEASE**, on Wednesday afternoon, October 25, Philadelphia County Medical Society, 2100 Spring Garden Street, Philadelphia, Pennsylvania. For information contact: Barbara B. Frank, M.D., Crozer-Chester Medical Center, 15th and Upland Avenue, Upland, Chester, Pennsylvania 19013.

Cancer of the Genitourinary Tract

The University of Texas M.D. Anderson Hospital and Tumor Institute will hold its 23rd **ANNUAL CLINICAL CONFERENCE**, November 2-3, Shamrock Hilton Hotel, Houston,

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In Brief

Texas. The topic of the Conference is "Cancer of the Genitourinary Tract." For additional information contact: Stephen C. Stuyck, Information Coordinator, M.D. Anderson Hospital and Tumor Institute, Houston, Texas 77030. (713) 792-3030.

Physicians and Schools

The American Medical Association will hold the 16th NATIONAL CONFERENCE ON PHYSICIANS & SCHOOLS, November 9-10, Hyatt Regency O'Hare, Chicago, Illinois. For information contact: AMA, Division of Scientific Activities, Department of Health Education, 535 N. Dearborn Street, Chicago, Illinois 60610.

6th W. Franklin Keim Memorial Seminar

The New Jersey Medical School and the Newark Eye and Ear Infirmary will hold the 6th W. Franklin Keim Memorial Seminar, HEAD AND NECK TUMORS, November 9-11. The program is approved for 18 hours AMA Category I credit. For information contact: Ki H. Han, M.D., Newark Eye & Ear Infirmary, 15 S. 9th Street, Newark, New Jersey 07107. (201) 268-8130.

Diseases of the Uterine Corpus

The Department of Obstetrics and Gynecology of the Wilmington Medical Center and the Office of Continuing Medical Education of Jefferson Medical College will sponsor a SYMPOSIUM ON DISEASES OF THE UTERINE CORPUS, November 16-17, Auditorium of the Nemours Building, Wilmington, Delaware. The program is acceptable for 10 credit hours in Category I of the AMA Physician's Recognition Award, 15 cognates by the American College of Obstetricians and Gynecologists, and 10 prescribed hours by the American Academy of Family Physicians. For information contact: Mrs. Boone, Department of Obstetrics and Gynecology, Wilmington Medical Center, P.O. Box 1951, Wilmington, Delaware 19899. Telephone: (302) 428-4660.

Neurologically Impaired Patient

The Garden State Rehabilitation Hospital and the Center to Promote Health Care Studies, Inc., will present a seminar on THE PRACTICING PHYSICIAN'S ROLE IN THE MANAGEMENT OF THE NEUROLOGICALLY IMPAIRED PATIENT in Toms River, New Jersey on September 29-30. The program is approved for 14 Category I AMA CME hours; 13 Category 2-D AOA hours; and 13 prescribed AAFP hours. Registration deadline is September 15. Contact The Center to Promote Health Care Studies, 14 Colvin Road, Scarsdale, N.Y. 10583.

Medical Staff Leadership Seminar

An AMA MEDICAL STAFF LEADERSHIP SEMINAR will be presented at two locations this fall: New Orleans, Louisiana, on September 29-30 and Miami Beach, Florida, on November 3-4. To register, contact the AMA Department of Hospitals and Health Facilities, 535 N. Dearborn Street, Chicago, Illinois 60610. Telephone: (312) 751-6653.

CLASSIFIED AD SECTION

Advertisements under the Classified Ad Section are charged at the rate of 30 words or less, set solid. One insertion \$4.00. Call the Journal office, 658-7596 for further information or placement. All advertisements are payable in advance. The Editorial Board reserves the right to edit copy. Closing date for new copy is the first of the month for inclusion in the current issue.

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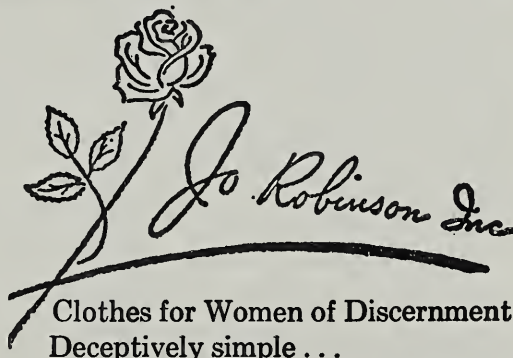


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cancer communiqué

FROM THE DELAWARE CANCER NETWORK*

UPDATE REPORT: BREAST CANCER MANAGEMENT PROGRAM

CORA L. HAYWARD, A.R.T.

July 1978 marked the beginning of the fifth and final year of the National Cancer Institute-supported "Prototype Network Demonstration Projects in Breast Cancer." The Delaware Cancer Network operates one of the ten demonstration projects in the United States. Plans are underway for a modified program beyond June 30, 1979. Statewide program activities of the past year have included professional education, public education, and data collection. A special focus has been on the annual follow-up of a minimum of 175 breast cancer patients entered in the program for each of the demonstration years.

The Breast Cancer Management program staff, under the leadership of Leslie W. Whitney, M.D., Principal Investigator for the contract, has continued to: 1) identify and meet educational needs for all levels of hospital staff, health agencies, and community programs; 2) update program and practice for those programs and individuals wanting the latest technology; 3) assure continuation and continuity of professional education programs throughout Delaware; and 4) demonstrate a multidisciplinary approach, including the medical and the allied health professionals, in the management of breast cancer patients.

Statewide education programs have been offered for 513 physicians, 634 nurses, and 360 social workers and other health care professionals. This has been accomplished through local and regional conferences, seminars, a series of inservice training programs, lectures, update reports to medical staff, and published material.

A major publication produced and distributed by the program staff is the *Guide to Breast Cancer Management*. The third edition, reflecting updated management systems for physicians, nurses, social workers, nutritionists, clergy, and

data analysts, will be published in the fall of 1978.

Program staff continues close work with the seven Network-affiliated hospitals, the University of Delaware, the American Cancer Society, Delaware Division, and local community agencies in developing and maintaining a joint effort in program planning and implementation. Overall, this past year's professional education activities have been evaluated as excellent.

Public education programming is provided by a purchase-of-service subcontract with the American Cancer Society, Delaware Division. The Society has been successful in reaching the at-risk population in their homes, community health agencies, churches, and organizations. A new focus in 1978 has been on "hard-to-reach audiences." Substantial progress has been made in reaching business and industrial groups and in maintaining cooperative programs with other agencies. Programs in breast self-examination continue, and some have become self-supporting in a number of community agencies and schools largely through the efforts of the Society's health educators.

Two significant statewide activities have been data collection and followup of breast cancer patients. Data are obtained through the Patient Management Data Collection System. This system collates information on all aspects of patient management: personal history, detection, diagnosis, clinical and pathological staging, treatment procedures, and the recording of supportive services. With the cooperation and support of the medical staffs and administrations of the Network-affiliated hospitals, data on approximately 225 breast cancer cases per year have been collected since July 1974. Three yearly comparative reports have been prepared from the collected data; a fourth report is in progress.

Mrs. Hayward is Project Manager for DCN's Breast and Colorectal Management Programs.

*An NCI-supported agency located at 1200 Jefferson Street, Wilmington, Delaware 19801. Tel. (302) 428-2113.

Cancer Communiqué

Data collection on new cases will terminate December 1978. The last six months of the program year will be devoted to evaluating the impact and effectiveness of the Breast Cancer Management Program.

Sixty Delaware physicians assisted in the follow-up study completed to date on patients entered into the Data Collection System. The completion of this major undertaking would not have been possible without the cooperation and participation of these physicians and their office staffs. This follow-up activity will also continue beyond the termination of the program in some modified form.

A major purpose in collecting data is to compare actual practice with the standards suggested in the published editions of the *Guide to Breast Cancer Management* and to measure the rate of change. At the end of five years, approximately 1,000 patients will have been entered into this comparison study. This group will continue to provide an excellent base for short- and long-term studies in patient management, morbidity, functional status, and mortality from breast cancer in Delaware.

Statistical reports will continue to be distributed to Network-affiliated hospitals, physicians, and other interested health care professionals assisting in the study. It is important to note that appropriate precautionary measures have been taken to insure compliance with legislation protecting confidentiality of all patients. No patient- or physician-identifying information can, under penalty of law, be disclosed in any report, including those reports made to personnel of the National Cancer Institute or other demonstration projects.

Growing pains, as expected, were experienced in the early stages of the program; however, the later stages of program expansion have been characterized by stability and positive program results. The concepts learned by study and experience are already being refined and duplicated in the current design of a management program for colon and rectum patients in Delaware.

Copies of the *Guide to Breast Cancer Management* and reports are available by contacting the Delaware Cancer Network office, (302) 428-2115.

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Brief Summary of Prescribing Information

DESCRIPTION Each tablet of PERCOCET[®]-5 contains 5 mg oxycodone hydrochloride (WARNING: May be habit forming), 325 mg acetaminophen (APAP).

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CONTRAINDICATIONS Hypersensitivity to oxycodone or acetaminophen.

WARNINGS Drug Dependence Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of PERCOCET[®]-5, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, PERCOCET[®]-5 is subject to the Federal Controlled Substances Act.

Usage in ambulatory patients Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using PERCOCET[®]-5 should be cautioned accordingly.

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PRECAUTIONS Head injury and increased intracranial pressure The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions The administration of PERCOCET[®]-5 or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special risk patients PERCOCET[®]-5 should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

ADVERSE REACTIONS The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include euphoria, dysphoria, constipation, skin rash and pruritus.

DOSAGE AND ADMINISTRATION Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. PERCOCET[®]-5 is given orally. The usual adult dose is one tablet every 6 hours as needed for pain.

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DELRO??

R. WALTER POWELL, M.D.

In the July issue of *Forum*, medical residents are exhorted to "vigorously reject the interference of social planners, political opportunists, and bureaucrats who frequently confuse the public good with their own desire to exercise power," in order "to retain some freedom in the practice of medicine and control in the care of your patients."¹ Depending on interpretation, this advice might well be misguided. In a recent Broadway play, "Shenandoah," the father of a family living in Virginia thought the Civil War could be fought around him without involving him or his family. Despite his refusal to go to war, the war came to him. No man living in society is independent of it, nor will society allow him to be uninvolved. Just so, the increased government regulation of medicine will involve all physicians, whether we "enlist" or are "drafted." It is DELRO's hope that by being incorporated (forming our own army) we can structure the battle in the hope of modifying if not winning the war.

In the June issue of *Legal Aspects of Medical Practice*, Hale Champion, Undersecretary of Health, is quoted: "By next October (1978) we will have PSRO's conducting review in all areas of this country . . . We are determined to get responsible bodies in place across the country. If we cannot obtain local physician cooperation, we will be forced to find alternative groups."² Further, Dr. Helen Smits, Director of the Health Standards and Quality Bureau, stated: "Those (PSRO's) that fail to address local problems, or to see any improvement in the problems they have addressed, will not have their funding continued; it as simple as that."²

Thus, at least two federal officials are saying that if physicians will not or cannot conduct these programs effectively, others will. It seems to me, therefore, that we can continue to "vigorously reject" the bureaucrats, or we can band together to accomplish common goals, perhaps then staving off further external regulation. Like the father in "Shenandoah" discovered, a con-

tinued isolationist policy will ultimately involve us in a much more distasteful way.

DELRO's Board of Directors has adopted the following corporate goals:

- Assure the medical necessity, appropriateness and optimal quality of health care services delivered under DELRO's scope of review.
- Assure that a dollar of health care is delivered for a dollar spent, the health care delivered consisting of medical necessity, appropriateness and optimal quality characteristics. (This is cost-effectiveness and is not to be confused with cost-cutting or cost-containment, both of which may result from these efforts, but which are not specific DELRO goals.)
- Remain an independent, local physician organization.
- Demonstrate accountability.
- Operate at a reasonable cost.
- Be appropriately managed.
- Pursue change or problem correction through education.

For the last year we have been performing utilization review:

1. To prevent the expenditure of funds for a high-priced bed when its use is not medically necessary; and
2. To insure the availability of hospital beds for those people in need of them.

Also, by performing and looking at medical audits we have been doing two chores:

1. Discovering where improvement needs to be made; and
2. Documenting the fact that good quality care is being provided.

What is the harm in these goals? They only spell better care for the patients in Delaware. Why, then, is there continued fear and rejection of DELRO?

Has DELRO done harm? Some difficult decisions have been made: denial of benefits to a

Dr. Powell is Medical Director of DELRO.

blind lady admitted solely because she lives alone and cannot find the key to her apartment, denial of benefits whenever the care is solely the provision of a home, etc. These are extremely difficult decisions to make, but our citizens, in the form of the Federal Government, have never provided funds to guarantee every person a home and until they do someone must decide whose condition merits acute hospital care and whose does not. Should not this decision rest always with physicians?

Some apparently medically unjustified practices which have come to light are the failure to initiate discharge planning at an early date, admission of "non-sick" people for diagnostic work-up and unnecessarily using hospital days for procedures which could be done on an outpatient basis.

The most frustrating problem remains the conscientious physician who cannot find an appropriate, insurance-reimbursable, post discharge destination for his patient. We have all been in this position on occasion and will be again, but, if we each try to be cognizant of community alternatives and use hospital time to best ad-

vantage, these problems can to a large measure be avoided.

All this the Department of HEW tells us. Is it anything we have not told ourselves already?

Physicians tend to draw on past contentment or future utopias, disregarding present reality. No one believes that everything we say or do will be judged as correct a century from now, but that does not give us the luxury to deny reality now. Legislatures are passing laws, at this moment, which make certain practices punishable by law, eg, "ghost surgery," misutilization of procedures, etc. It would be unrealistic to assume that government is going to be less involved in medical practice than it is now. DELRO's belief is that it is better to adopt modifiers of government policy or tenets which will make government regulation unnecessary so that medical practice will be more productive and satisfying to both physicians and patients.

We solicit your support and involvement as we pursue these goals.

REFERENCES

1. Edwards CC, quoted by Sheldon GP: Valedictory for Medical Residents. Forum on Medicine p 14, July, 1978.
2. Seiderberg GR: PSRO's of the Second Kind. Legal Aspects of Medical Practice pp 25-26, June, 1978.

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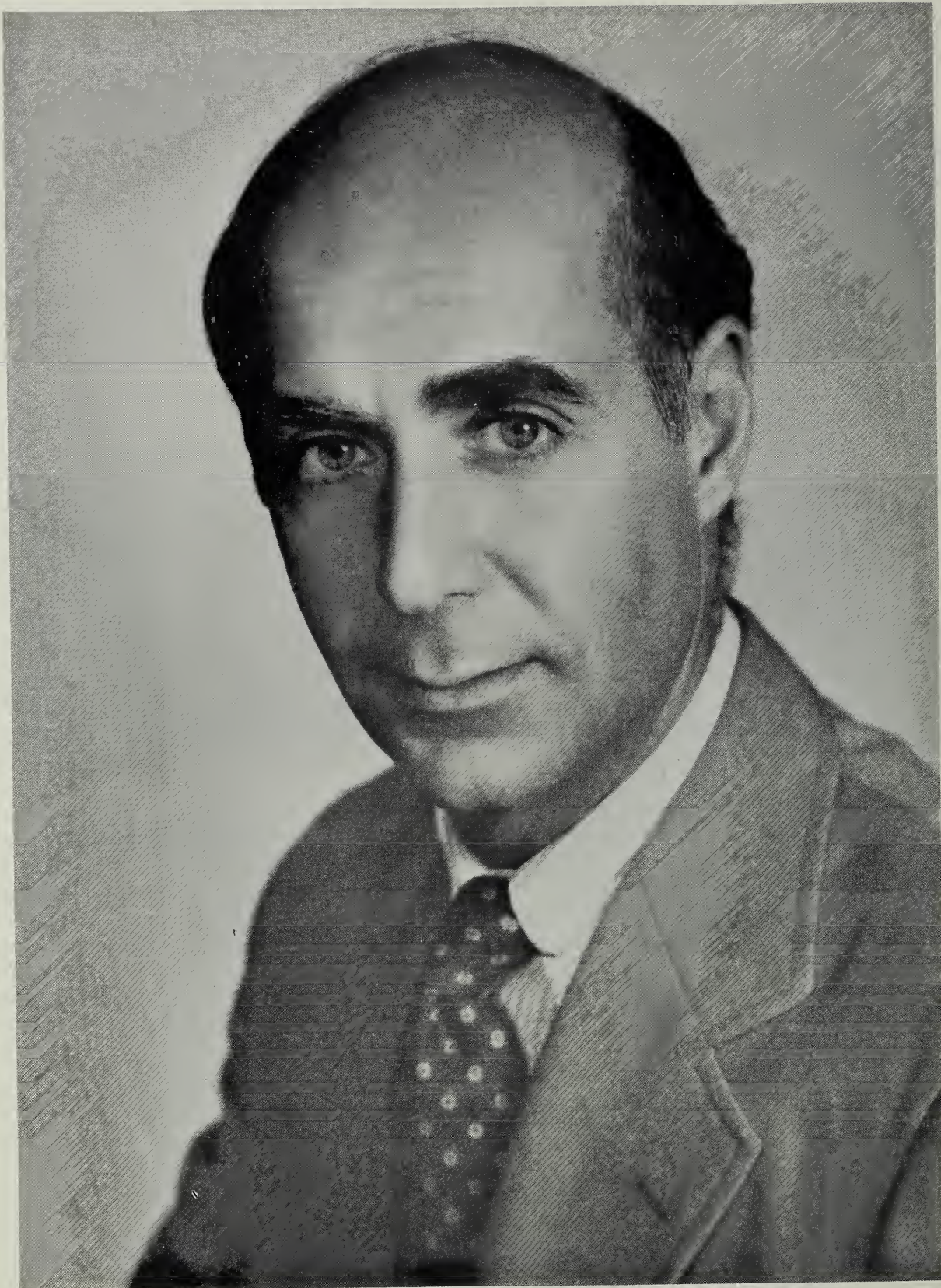
For nine years Homemakers Upjohn has been a name people associate with trust, care, and concern. In these years we've grown...by number of offices, kinds of services, the people we take care of, and the people who work with us. The name changes, but our commitment to meeting a variety of health care needs in an environment of quality, dignity, and professional excellence continues.

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ANTHONY L. CUCUZZELLA, M.D.

President, Medical Society of Delaware, 1978-1979

President's Page

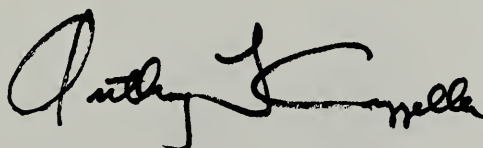
AN ACTIVIST ROLE

The Medical Society of Delaware enters its 190th year, with more practicing physicians, more American-trained house officers in the hospitals of Delaware, a well-established teaching program, in cooperation with Thomas Jefferson University, and ready access to new advances in medical technology and equipment. However, problems face medicine today as they have undoubtedly in the past, and they present themselves to this incoming President of the Medical Society as they have to past incoming Presidents. Some of the problems of the past remain and, as old ones have been resolved or disappeared, new ones have arisen to replace them.

The "Malpractice Crisis" has not been resolved, but it is certainly less a problem today than it was three years ago. The problem of medical costs is currently in the forefront and, as never before, government has become involved in efforts to contain and control medical costs in a fashion that is not always beneficial to the patient or to medicine. Directly related to the problem of medical costs are efforts to establish, in Delaware, new ways of health delivery. These include health maintenance organizations, statewide health planning, certificate of need, and the establishment of group practices. New methods for the delivery of health care will be proposed by physicians and also by those seeking to deliver medical care without the supervision or guidance of physicians. Additional solutions will be proposed for controlling medical costs, not the least of which will be national health insurance. Each of these must be carefully studied and evaluated by the Medical Society of Delaware.

The American Medical Association has taken an active role in proposing health legislation and in attempting to find solutions to rising medical costs. The Voluntary Effort of the American Medical Association and the American Hospital Association and the American Federation of Hospitals has been implemented on a national basis, and this Voluntary Effort is actually showing results with a national as well as a statewide decrease in the rise of medical costs.

I am proposing that medicine continue its activist role in dealing with the problems that beset medicine. A passive role cannot be tolerated today.





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A REVIEW OF 147 CASES OF ADENOCARCINOMA OF THE PROSTATE TREATED WITH RADIATION THERAPY AT THE WILMINGTON MEDICAL CENTER 1967-1974

PETER R. HULICK, M.D.

Introduction

From 1967 to 1974 147 patients with histologically proven carcinoma of the prostate, Stage A, B, or C, were accepted for a course of external radiation therapy at the Wilmington Medical Center. This paper attempts to describe that patient population, illustrate their mode of therapy, tabulate the rate of control of their local tumors, and report the incidence of complications.

Anatomy of the Prostate Gland

The prostate gland is situated at the proximal portion of the male urethra. Physiologically, it is a member of the male genital system. Anatomically it is intimately related to the urinary tract. The prostate is arbitrarily divided into five lobes. The posterior lobe lies posterior to a plane passing through the ejaculatory ducts. The anterior lobe is that portion which forms the roof of the prostatic urethra. The two la-

teral lobes are composed of that portion which lies between the anterior and posterior lobes. The median lobe forms the floor of the prostatic urethra.

The lymphatic drainage of the prostate arises from the acini of the gland. (Figure 1) The lymphatic channels become larger as they form a dense network in the subcapsular region. They are most abundant in the posterior and superior surfaces. Four collecting trunks follow the arteries of the prostate. 1. The external iliac pedicle arises from the base and upper posterior surface of the gland, passes above the terminal segment of the ureter, and terminates in the middle nodes of the external iliac chain. 2. The hypogastric pedicle begins in the inferior aspect of the gland and runs laterally with the prostatic artery to the hypogastric nodes. 3. The posterior pedicle arises from the posterior surface and runs posteriorly toward the nodes located at the sacral promontory or just medial to the second sacral foramen. 4. The inferior pedicle runs inferiorly along the anterior surface of the

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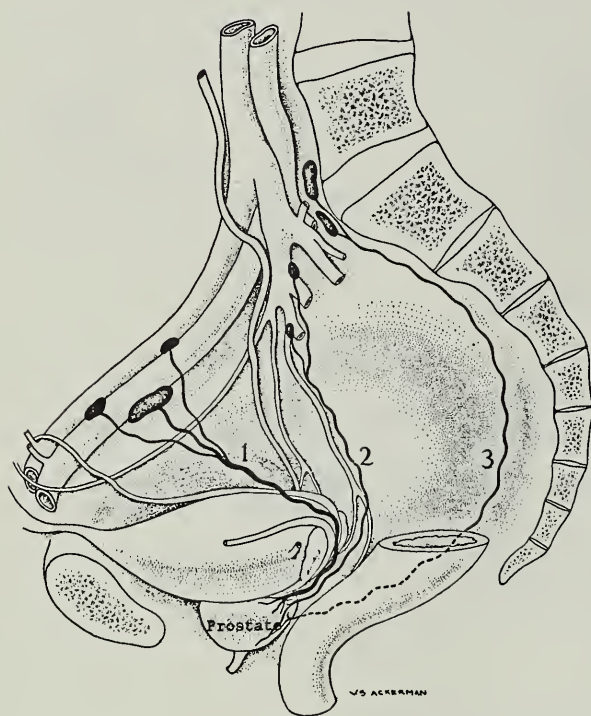


FIGURE 1

Schematic representation of the lymphatic drainage of the prostate, showing the external iliac pedicle (1), the hypogastric pedicle (2), and the posterior pedicle (3). The inferior pedicle, which also ends in the hypogastric nodes, is not illustrated.

Figure 1 is reproduced with permission from del Regato JA, Spjut HJ: *Ackerman and del Regato's Cancer*, ed 5. St. Louis, The CV Mosby Co, 1977.

prostate to the perineal floor to the pudendal artery, ending in the hypogastric nodes.

The lymphatics of the prostate also anastomose with those of the fundus of the bladder, the seminal vesicles, the ampulla of the ductus deferens, and the rectum. They can be regarded as draining into the external iliac, and the hypogastric and the sacral lymph nodes.

Patient Population

During the years beginning January 1, 1967 and ending December 31, 1974, 147 patients were accepted for definitive radiation treatment of biopsy-proven carcinoma of the prostate. The average age of the patients was 66 years (stan-

dard deviation 8 years). (Table 1) The median age was also 66 years, with 71 patients younger, 67 older, and nine exactly 66 years of age.

In all cases, the histopathologic diagnosis was adenocarcinoma. This was subdivided into 26 patients in whom the adenocarcinoma was not graded, 96 with well-differentiated tumors, 18 with poorly differentiated tumors, and seven with anaplastic adenocarcinoma. The pathologic sections were interpreted by various pathologists whose locations reflect the geographic distribution of the patients and their referring urologists. The majority of patients were from Wilmington, Annapolis, Salisbury, and southern New Jersey.

All patients were examined by two radiation therapists, and agreement was established regarding the stage of disease. Patients were divided into three stages: Stage A (nine patients, 6%) in which the disease was occult, ie, clinically not apparent but biopsy proven, the biopsy having usually been obtained for suspected benign prostatic hypertrophy; stage B (68 patients, 46%) in which the disease was clinically limited to the prostate; stage C (70 patients, 48%) with

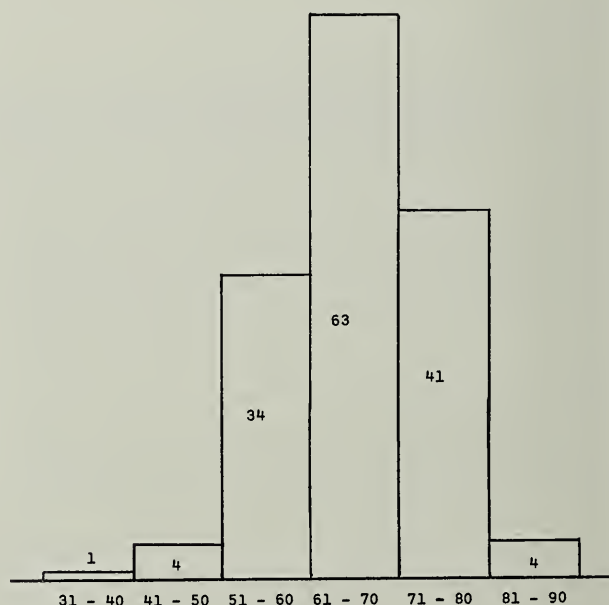


TABLE 1

Age distribution of 147 patients treated for Stage A, B, or C adenocarcinoma of the prostate with radiation therapy at the Wilmington Medical Center 1967-1974.

extracapsular extension of the carcinoma. Patients with more advanced disease, such as distant metastases, were excluded from this study. Presenting symptoms were almost invariably those of prostatism, a loosely defined syndrome which includes the symptoms and signs of nocturia, diminished stream, frequency, hesitancy, frank obstruction, dysuria, urgency, hematuria, dribbling, and hematospermia. Other symptoms, such as anal pain, perineal pain, sensation of rectal fullness, and pain in bone, were seen less commonly. Approximately 70% of patients had one or more symptoms suggesting "prostatism."

Modality of Treatment

All treatments were supervoltage, either with a Cobalt-60 unit or a 4 MeV linear accelerator. Two modalities were utilized. Modality A consisted of irradiation of the entire pelvis to a dose of 4000 rads in four weeks' time, utilizing a four field "box" technique, followed by an additional 2500 rads in two weeks' time via a 360° rotational 8 x 8 cm portal. Modality B consisted of delivering 7,000 rads in six weeks' time utilizing solely 360° technique with an 8 x 8 cm field for the first 5000 rads and 7 x 7 cm for the remaining 2000 rads. All the patients in stage A were treated with modality B. Of those having stage B disease, ten (14%) were treated with modality A and 58 (86%) with modality B. Of the 70 patients with extracapsular extension (stage C) 22 (31%) were treated with modality A and 48 (69%) with modality B. (Table 2) The increasing proportion of patients treated to the

entire pelvis as the stage advanced reflects the facts that a small rotational portal does not adequately treat a large tumor, and that there may be a need for also treating the pelvic lymph nodes in more advanced cases. It must be kept in mind that an early stage C can have a smaller tumor bulk than an advanced stage B that has not penetrated the prostatic capsule; this is the reason that certain stage B's are treated with modality A while early stage C's are treated with modality B.

Results

All patients were examined by the radiotherapist at least weekly during the entire course of therapy. In 125 patients (85%) clinical regression of the tumor was detected by the end of the treatment course. All patients were then examined again one month later, at which time an additional 19 (13%) had clinical evidence of tumor regression. Only three patients (2%) failed to show improvement after one month. It is recognized that it can take years for a neoplasm of the prostate to regress completely following treatment with radiation, and for that reason a response to treatment is defined here as a decrease in size or softening of consistency of the neoplastic mass, a more adequate urinary stream, or objective improvement in ureteral obstruction as seen on repeat intravenous pyelography.

Analysis of the improvement of obstructive symptoms reveals that 23% of all treated patients enjoyed complete disappearance of their obstructive uropathy within one month of the completion of therapy; 39% experienced definite improvement in their symptoms; 8% obtained no improvement. The remaining 30% had no symptoms prior to radiation therapy.

Followup of 143 of the 147 patients for a minimum of two years was obtained. Four were lost to followup and for statistical purposes are assumed dead with uncontrolled carcinoma. Actuarial survival rates, as calculated by the Berkson-Gage method, are illustrated in Table 3. Stage A disease patients have a five-year survival rate of 77%; stage B, 61%; stage C, 49%; and an overall five-year survival of 56.4%

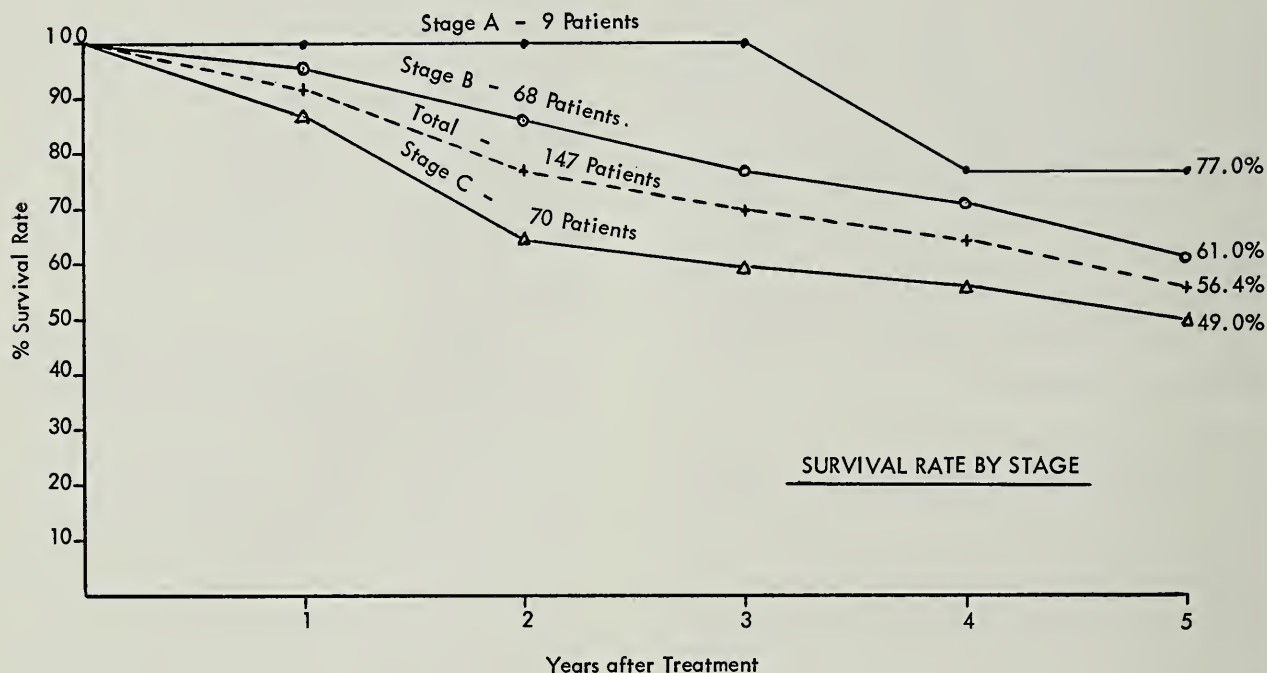
It must be recognized that irradiation of the pelvis and prostate is strictly a local process;

TABLE 2

ADENOCARCINOMA OF THE PROSTATE MODALITY OF TREATMENT

A	Total pelvis	4000 rads/4 weeks
	+360° rotation (8x8)	2500 rads/2 weeks
B	360° rotation (8x8)	7000 rads/6 weeks
	Stage A = Modality B	100 %
	Stage B = Modality B	86 %
	Modality A	14 %
	Stage C = Modality B	69 %
	Modality A	31 %

TABLE 3
CANCER OF THE PROSTATE



the therapy is effective only on malignant cells that are within the treated volume. For the purpose of evaluating the therapeutic results of irradiation, one must distinguish between control of local disease and survival. Treatments are considered successful if the primary prostatic malignancy is controlled, even though metastases may have developed. Of the 147 patients with stage A, B, or C disease, there was control of local disease in 91 (62%). Of these, 71 are alive and free of any evidence of tumor; nine are alive with distant metastases but with the primary tumor controlled; two have died with no evidence of malignancy; nine have died of metastatic carcinoma with the primary tumor remaining controlled. (Table 4) The minimum length of followup is two years, the maximum eight years, and the mean 3.05 years.

The influence of histologic grade of the malignancy on the survival rate is as expected, with the survival rate directly proportional to the degree of differentiation of the tumor. Crude survival after a minimum of two years followup (not corrected for death due to intercurrent disease or those patients alive with disease) is 49% for well-differentiated tumors, 33% for

poorly differentiated, and 28.5% for anaplastic carcinoma. The survival rate for those not graded was 61.5%, which perhaps suggests the

TABLE 4

Rate of local control of primary tumor of 147 patients with adenocarcinoma of the prostate treated with radiation therapy at the Wilmington Medical Center 1967-1974.

Alive—No evidence of disease	71
Alive—Primary tumor controlled, with metastases	9
Dead—No evidence of disease	2
Dead—Primary tumor controlled to time of death	9
	—
	91
Alive—Primary tumor not controlled	7
Lost to followup	4
Dead with primary tumor not controlled or status of primary tumor not known	45
	—
	56

TABLE 5
INFLUENCE OF TREATMENT TECHNIQUE ON IMMEDIATE
RADIATION REACTIONS (147 pts; 1967-1974)

	Moderate Dysuria	Severe Dysuria	Moderate Intestinal or Rectal	Severe Intestinal or Rectal
TP + ROTATION	20%	0%	62.5%	2.5%
ROTATION	32%	0%	56%	0%

spectrum of differentiation of tumors in that group.

Complications Due to Treatment

Patients were carefully monitored for radiation reactions. These were divided into acute and chronic, minor and major. Immediate or acute reactions are defined as those which occurred and disappeared within three months of completion of treatments. (Table 5) The frequency of acute reactions was not dependent on treatment modality; however, those who eventually developed chronic major complications were usually treated with modality A. Most immediate reactions responded well to administration of diphenoxylate hydrochloride with atropine sulfate (*Lomotil*, Searle) for small bowel diarrhea, phenazopyridine hydrochloride (*Pyridium*, Warner/Chilcott) for radiation cystitis, and an appropriate antibiotic for documented urinary tract infection.

Of the 147 patients treated, there were nine (6%) chronic minor sequelae: one patient had persistent cystitis and/or hematuria; five patients had persistent proctitis and/or rectal bleeding; three patients had radiation fibrosis of the urethra, bladder, or suprapubic subcutaneous tissues. There were five (3.5%) major complications including three patients with bladder complications, two with severe rectal and bladder complications, and one who eventually required colostomy.

Discussion

The survival rates in this series, stage for stage, are very similar to those published by Fletcher in his series of 360 patients treated at M.D. Anderson Hospital and Tumor Institute.¹ As one would expect, survival rate is increased by detection and treatment at earlier stages and

in those patients with lower grade histologies. Bladder infiltration was a significant adverse prognostic factor, as was a long interval between the initial diagnosis and the institution of therapy. Little if any difference was found in the group that was treated prophylactically by orchiectomy or placed on estrogens; such hormonal manipulation should therefore be reserved for patients with recurrent or metastatic disease. Sexual potency was preserved in approximately 70% of patients, which is in marked contrast to the nearly 100% incidence of impotence following radical prostatectomy. The survival in stage A and B disease treated with radiation therapy approaches that achieved with radical prostatectomy (50-91% in carefully selected series). Only 2 to 10% of all patients, however, are candidates for radical surgery because of the presence of extracapsular local disease or metastatic adenopathy. In these, radiation therapy is definitely the appropriate treatment.

Conclusion

In conclusion, the 147 patients in this series appear to be similar in characteristics to those in previously published reports. The survival rate and rate of local control appear to be comparable to that achieved at other institutions, and are improved in those patients with less advanced disease and well-differentiated histology.

The sexual history available from the 147 patients in our series is too limited to be statistically significant but sexual potency appears to have been preserved in a high percentage of patients. The survival rate with radiation therapy appears to be similar to that of patients cases treated by radical prostatectomy in other series.

REFERENCE

1. Fletcher G: Textbook of Radiotherapy, 2nd ed. Philadelphia, Lea & Febiger Co, 1973.

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• *nuclear medicine*

THE PHYSICIAN'S ROLE IN COST OF HOSPITALIZATION:

AN ANALYSIS OF FOUR ADMISSIONS

GARY M. OWENS, M.D.
BERNADINE Z. PAULSHOCK, M.D.

At the present time almost 160 billion dollars (about 9% of the Gross National Product) is spent on health care.¹ (Figure 1) The duPont Company spent 69 million in 1976 on health insurance, up 14% from the year before.² HEW has recently stated, although there are health economists who dispute it, that each physician in practice generates an average of \$250,000 worth of medical costs per year.³

In this paper we examine the cost of two recent non-surgical and two recent surgical hospitalizations at the Wilmington Medical Center.

Case Presentations

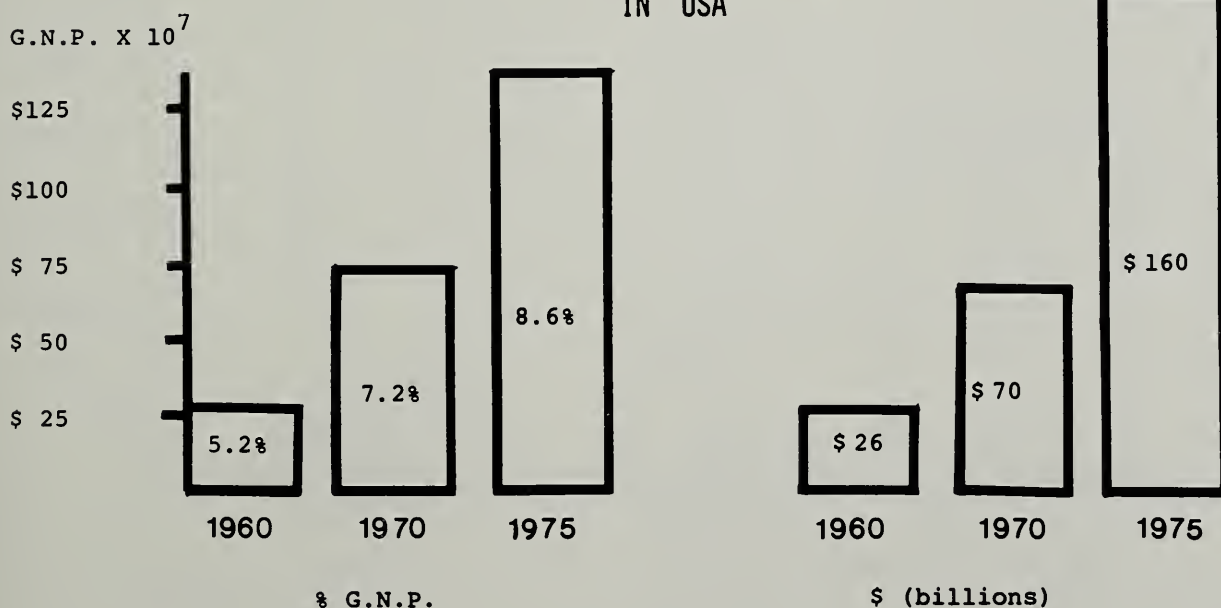
Figure 2 represents the bill of a 57-year-old

man who was admitted via the Emergency Room with classic symptoms of myocardial infarction. His hospital course was complicated by a urinary tract infection. Room charges accounted for almost 68% of his bill. Laboratory fees, the next greatest percentage, represented 10%; these charges include a blood collection fee of \$9 which is charged once to all patients.

Figure 3 represents the hospital bill of a 36-year-old known hypertensive male school teacher who was admitted because of hematemesis and a history of recent tarry stools. The diagnostic impression at the time of admission was hemorrhagic alcoholic gastritis with a possibility of impending delirium tremens. His room rent charges

FIGURE 1

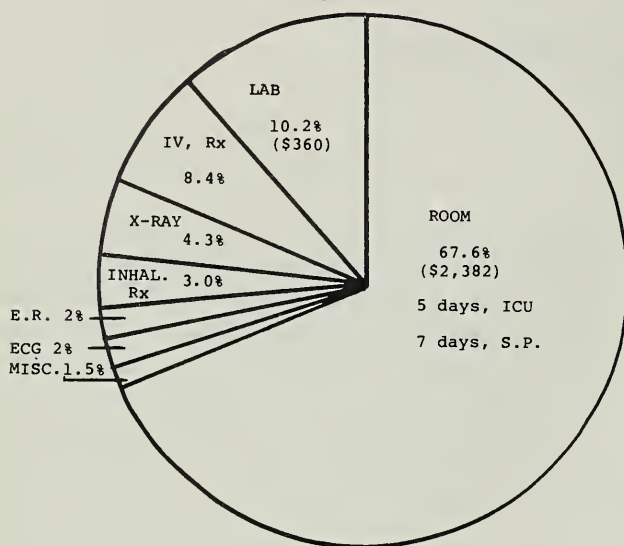
\$ FOR HEALTH CARE
IN USA



Dr. Owens was a third-year resident in Family Practice at the Wilmington Medical Center when this paper was prepared. He is now in private practice in Wilmington.

Dr. Paulshock is Associate Program Director of the Family Practice Residency Program at the Wilmington Medical Center, Wilmington, Delaware.

FIGURE 2



PATIENT # 1 - M.I.
\$3,525
12 DAYS

were 56% of his bill; laboratory charges, 20%; x-ray charges, about 1%. The only item on his bill of \$875 known to be non-reimbursable by Blue Cross was a \$10 fee submitted for consultation by the Alcoholism Service.

Figure 4 diagrams the bill of a 43-year-old man who was admitted for repair of an inguinal hernia, which he had first noticed approximately a year and a half ago and which was associated with frequent and worsening pain. Of his hospital bill of \$747, approximately 51% was for his room; \$244 or 33.5% was operating room charges, including \$39 for the recovery room. His pre-operative laboratory work, electrocardiogram, and chest x-ray represented about 11% of his total bill.

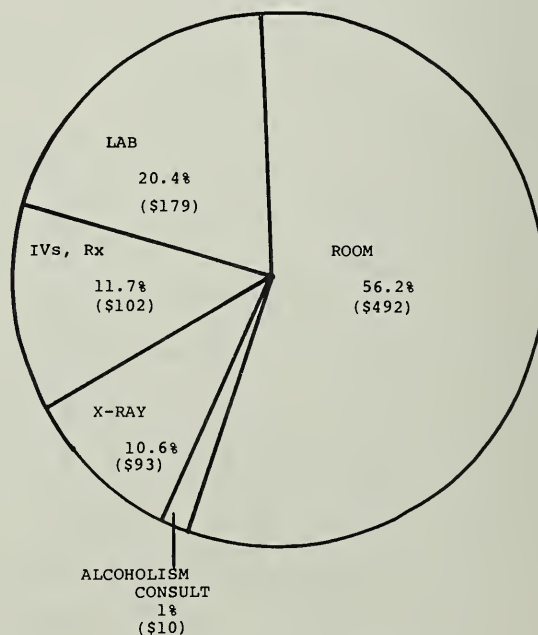
Figure 5 represents the hospital bill of a 44-year-old woman admitted for cholecystectomy. Cholelithiasis had been diagnosed during an outpatient workup for symptoms of fatty food intolerance. Her operation was achieved without complications except for a minor wound infection. Room charges represented 51.5% of her bill. Her OR charges represented another 26%. Pre-operative and post-operative laboratory work

was 11.5% of her bill. Routine pre- and post-operative inhalation therapy—(by routine, we mean that her chart does not indicate any particular respiratory problem)—was about 6% of her bill. The size of this particular item was possibly the most unexpected to us of all the items in these four bills. One 80 cent item on her hospital bill was marked non-reimbursable by Blue Cross—sanitary supplies needed for menstrual hygiene.

A recent Blue Shield advertisement showed how the average cost of a gallbladder operation has risen in recent years.⁴ By national standards, the cost of this procedure at the Wilmington Medical Center is about average. (Figure 6)

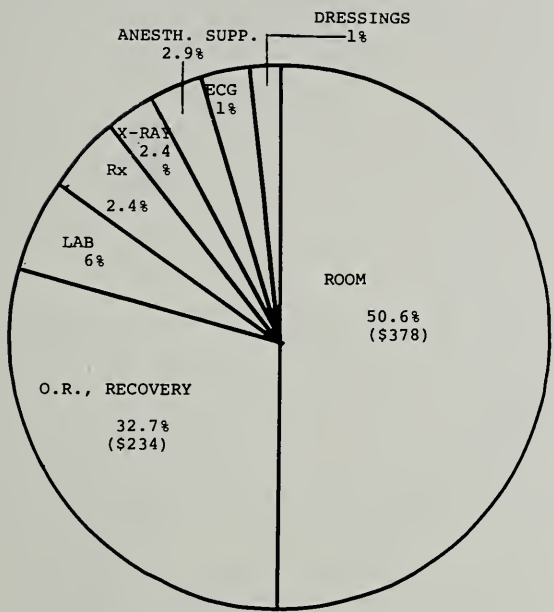
In these four patients we have not attempted to judge the appropriateness of any individual laboratory test, medication, or procedure. It is, however, apparent by inspecting the charges that the only way significant savings could have been achieved by the physician in these four admissions was by reducing hospital stay by one day or by not admitting the patient at all. For example, discharging the patient with myocardial infarction one day sooner would have resulted in

FIGURE 3



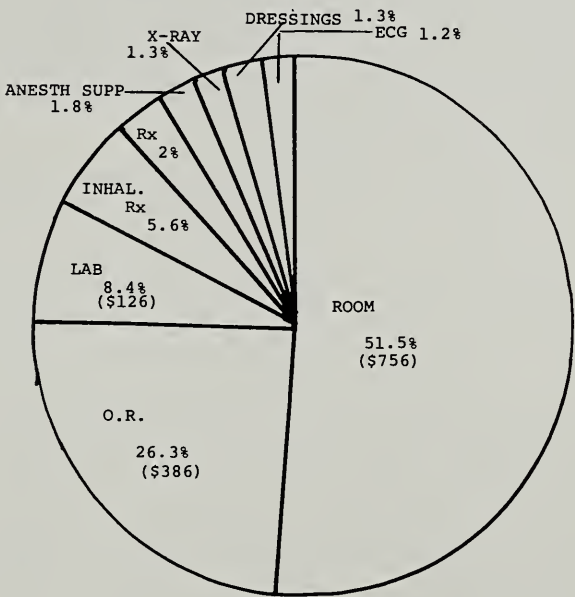
PATIENT # 2 - G.I. BLEEDING
\$875
4 DAYS

FIGURE 4



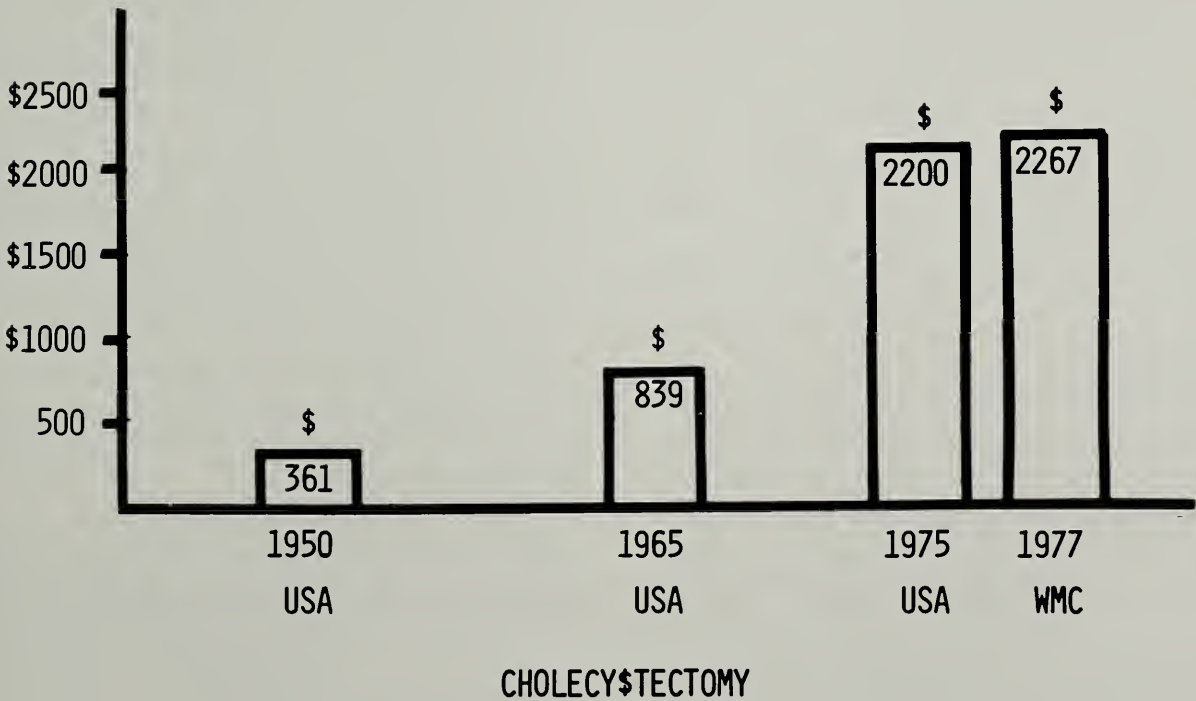
PATIENT # 3 - HERNIORRHAPHY
\$747
3 DAYS

FIGURE 5



PATIENT # 4 - CHOLECYSTECTOMY
\$1,467
6 DAYS

FIGURE 6



saving 3.6% of his total hospital bill. For the shorter admission, one day would have represented a larger percent of savings. Since the hernia patient stayed only three days, it seems unlikely that earlier discharge was feasible unless the operation was not performed as an inpatient at all. (Figure 7)

Figure 8 represents in graphic fashion the hospital charges versus physician charges for the four patients presented. Included in the physicians' charges are the bills submitted by the patients' private physicians as well as the charges for anesthesiologists and ECG and x-ray physicians. Laboratory physicians' charges are not included because they are not separated out in the hospital billing system. The patient with a myocardial infarction was actually a ward service patient; we have graphed for him a fee which a colleague internist has told us he would have charged for that particular patient.

Summary

Physicians have been called the gatekeepers to the overall cost of health care since they are directly or indirectly involved in nearly 70% of all health care costs.⁵ Inspection of the costs of these four hospitalizations suggests that the physician plays his most potent role in cost determi-

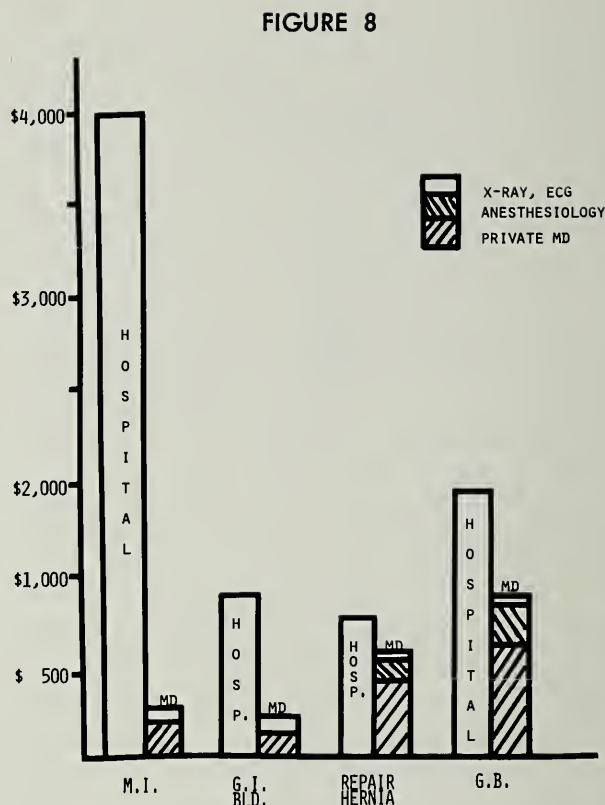


FIGURE 7

		SAVINGS IF 1 DAY EARLIER DISCHARGE	POTENTIAL SAVINGS
M.I.	1 DAY	\$ 126	= 3.6%
	12 DAYS	\$3,525	
G.I. BLEEDING	1 DAY	\$ 123	= 14.0%
	4 DAYS	\$ 875	
CHOLECYSTECTOMY	1 DAY	\$ 126	= 8.6%
	6 DAYS	\$1,467	
HERNIORRHAPHY	1 DAY	\$ 126	= 16.9%
	3 DAYS	\$ 747	

nation at the point when he makes the basic decision to treat the patient by hospitalization.

In these four patients, the typicalness of whom is only conjectural, their physicians did not have very much influence on significant segments of the hospital bills. Had we chosen to analyze the bills of patients with diagnostic problems or severe lingering illnesses, the data may well have been very different. Nevertheless, common sense and the current times require that awareness of the varying cost of their patients' hospitalization should be included among the professional responsibilities of admitting physicians.

We are suggesting that scrutiny of their patients' hospital bill should become a regular part of the responsibilities of house officers and attending physicians.

ACKNOWLEDGMENT

The illustrations for this paper were prepared by June Swafford, and photographed by Donald Russell and Douglas Bugel, Wilmington Medical Center.

This paper was adapted from a presentation to the Delaware regional meeting of the American College of Physicians.

REFERENCES

1. Medical Economics, p 253, October 3, 1977.
2. DuPont Company News, 6:6, 1977.
3. AMA Medical News, p 4, September 1977.
4. Schwartz H: New York Times, October 30, 1977.
5. Blue Shield News, p 4, November 1976.

COMMON SUGGESTIONS ARISING FROM SURVEYS—PART I

LEIF C. BECK, LL.B., CPBC
VASILIOS J. KALOGREDIS, J.D.

While our general "surveys" of medical offices deal with all aspects of clients' practices, the number of areas of common concern surprises us. Accordingly, we have culled a number of common suggestions from reports we have drafted in hopes their publication would help all physicians.

A "survey" would involve anywhere from one to six man-days of consultants' time in a medical office. The actual time would, of course, depend on the size of the practice, the number of personnel (both physicians and aides) involved, the complexity of the practice and its problems, and the like. Very large, clinic-sized offices might require still more on-site consultant time.

We hope this article, containing our brief observations, will help practices avoid some common medical office problems.

PERSONNEL MATTERS

Job Evaluations and Salary Reviews

Too many offices have no specific, regularly scheduled procedure for reviewing their aides' job performances. Similarly, many offices routinely grant their personnel periodic pay raises without critically determining how well-deserved they may be. We strongly believe that office personnel should not all receive a standard percentage raise based purely on the increased cost of living.

Various offices have presented us with problems of a difficult or unproductive employee. Too often, that employee has never been told of the dissatisfaction with her work. In such instances, it is obviously difficult for an office to deal with the employee.

Each office should have a regularly scheduled (usually once each year) job evaluation and salary review discussion with each individual employee. At that time, the employee can be told whether the doctor or doctors are satisfied with her work or have criticisms. Job performance can be stressed as the determining factor in setting salaries while informing aides of any upcoming raises. An employee who has not had a satisfactory rating might, knowing the situation, decide either to improve her performance or seek other work—either approach probably beneficial to the office.

Office Staff Meetings

Many of the surveyed offices rarely have a meeting between all office staff and doctors. Doctors commonly respond that the doctors had such a meeting once or twice, "but they didn't work so we dropped them."

The office staff meetings can be the most helpful way both to develop a team spirit among all employees and to work out specific office problems. Each aide undoubtedly will have certain recommendations for how certain activities can be improved, if only given the chance in a constructive office meeting.

The first couple of office staff meetings are likely to be unsuccessful. It probably takes those meetings to "break the ice" and begin developing a feeling among everyone that the problems can be discussed comfortably and constructively. That is why we urge so many survey clients to resume holding office staff meetings and persevere until they become effective.

Individual Job Assignments

Small medical offices can suffer from the old idea of having each aide perform all duties. We

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feel strongly that the aides in such offices must have capacities to perform all work; however, we even more strongly urge that each person have specific responsibility for certain jobs. Even solo practices with two or three employees should reduce to writing each person's specific job assignments.

With such job assignments, an employee will clearly know her responsibilities. Similarly, the employer-doctor will know who to hold responsible for each function's success or failure. The employees' assignments should be broken down into "primary responsibility" and "secondary responsibility." The latter category involves those areas requiring a person's coverage when the primarily responsible person is on vacation, out sick, to lunch, or otherwise occupied. This retains the capacity to adequately cover all jobs in a small office while having special responsibilities.

The principle of job assignments is simple. A person tends to perform work better if she knows what she is responsible to do. Conversely, if

everyone is responsible for the jobs, then no one is responsible.

Lunch Breaks

A few offices have presented complaints that aides are never able to leave the premises for lunch. Sometimes the doctors contend that the aides are as well served being able to have lunch within the office (sometimes in attractive employee lounges) and therefore should not have to leave the premises. We feel each aide should have the opportunity to take a lunch break and leave the office premises. It provides the person an opportunity to "recharge" her enthusiasm for the job by getting away, even if only for half an hour. In such cases, even if the aide decides to "eat in," it will at least have been her own decision. The level of free choice is important.

Special Jobs

Some offices have special patient activities to whom a specific aide is assigned. For example, some pediatric practices have EPSDT clinics, while various internal medicine practices may have a number of blood pressure revisits, special training programs, and the like.

Some offices have assigned a single aide to the special job or jobs in the thought that they can be developed almost without physician involvement; however, the jobs are often far less than full-time since the volume of patients is still small. What often results is a less than fully busy aide, with ill-defined duties for her remaining time and energies.

In such cases, we have encouraged offices to reduce the number of hours during which patients may visit for the special clinics. For instance, if the EPSDT program can be accomplished in two three-hour sessions, it is preferable to schedule such work on two specific half-days every week. The responsible aide would then be fully occupied with the EPSDT work on those two time blocks and she could be given primary responsibilities in other areas for the rest of the week. This tends to tighten up that aide's work both to her and the rest of the staff's satisfaction.

Use of Physician's Assistants

We occasionally visit offices in which the doctors are totally overwhelmed by demands for

office time. For example, we know of some busy specialty surgeons who are now finding it almost impossible to schedule office time for postoperative check-ups, routine visits, and new patient visits. They are scheduled for weeks in advance, and it is becoming a problem of properly caring for those patients needing office re-visits.

Although some suggestions can be made with respect to how these offices schedule patients, there comes a point when we must simply concede that the doctors are too busy. The usual solution would then be to recruit and engage an additional physician-member; however, this can be an extremely serious step which might not be proper for the practice or its present members.

Another solution to this dilemma is to recruit and hire a physician's assistant, a trained paramedical person who should have the capacity to perform many of the routine office visit activities. Specialty practices are now able to recruit physician's assistants from a variety of programs, and it is really the only other feasible solution to hiring an additional physician. The secret to physician's assistant work, of course, is extremely

well-organized supervision and review by the physician or physicians. Some doctors tend to say their patients would not accept being seen by less than a medical doctor. This objection really need not apply to many circumstances. Particularly when one is dealing with postoperative followups, routine re-checks, and the like, we believe any patient group can be educated to the importance of having the work performed by a physician's assistant.

OFFICE FACILITIES

Willingness to Move

Too often offices tend to resist moving to better quarters. The result is inefficiency, less than totally effective medical service, bad business systems and resulting lost income, and general frustration among all doctors and staff. It is not worth these results for such offices to stay put.

Similarly, some doctors practice in offices which cause substantial drains on their time. The primary examples are surgeons with offices far removed from the hospitals they serve even though much more convenient office space might

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be available. We think any savings in rent are "false savings" in those cases, for the doctor's travel time can be replaced by opportunities to see more patients in the office, greater availability in the hospital, or simply more free time for pleasure.

Philosophy Toward Building Ownership

Some doctors ask us whether they should build and own their medical office facilities. We believe this question is often one of pure economics which can be determined if the doctor or doctors then recognize their two separate roles—as owner-investors on the one hand and as tenants on the other hand.

We urge these doctors to have very careful mathematical projections prepared of all costs involved in constructing and operating their buildings *before* entering into the transaction. Those projections should build in the opportunity for a 10 percent minimum return on the owner's investment. The result of such a projection should enable one to decide how much rent needs to be paid to produce this kind of return to the owner-investors. If that figure is reasonably comparable with the rent the practice would otherwise have to pay, then ownership might be a good economic step. If, however, the practice must pay considerably higher rent in order to give its doctor or doctors a fair investment return on the building, we think the practice and

its doctors are generally better off leasing office space and staying out of the real estate business.

PRACTICE BUDGETS

Why, we wonder, does a solo or two-man practice function on such casual business procedures? Even those small practices are probably \$100,000 to \$250,000 businesses which, if anything but medical, would have carefully constructed advance budgets.

We therefore urge some survey clients to establish a budget of their projected income and expenses before each year begins. These numbers are really fairly easy to develop if the doctor or doctors would only give some undivided and conscientious attention to them. There is nothing magic in the system that is beyond the doctors' capacities as "non-business oriented people."

We have recently worked with a couple of good practices in developing their own practice budgets. Those exercises in turn help the doctors decide what salaries they should pay themselves, whether their fee structures are satisfactory, whether they should in fact obtain some equipment they thought would be useful, whether they should recruit and hire another doctor, etc. Decisions like these are too often made in a vacuum. The practice budget procedure can help the doctors make more informed decisions.

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Special Reports

HYPERKINESIS: STILL UNSOLVED AND UNRESOLVED

The literature, medical and lay, is rampant with continued discussion of scientifically unproven diagnostic criteria, etiologies, and therapeutic programs regarding the perplexing problem of hyperkinesis. The truly hyperactive child, untreated by any of the modalities available, is a continuing source of consternation for the physician, the teacher, his/her own peer group, the neighborhood, the parents especially, and—probably, most importantly—for the child him/herself, for, whether “treated” or untreated, the child certainly must become aware that he or she is “different” from the great majority of other children. This awareness must have secondary psychological results including manipulative behavior, power struggle games, potential increased loss of self-image, or perhaps even the feeling that society must accept him, whatever his behavior traits may be because the hyperactive child has no control over his actions.

According to Cantwell, “Sustained motor activity, short attention span, poor impulse control, easy distractibility, and poor tolerance to frustration” constitute the cardinal features of hyperactive children.¹ But how does one measure, critically and scientifically, such semantic generalizations? The incidence of hyperkinesis was placed at between 3 and 10% seven years ago.² With increased physician, school, and parent awareness of this syndrome, there now appears to be an even higher incidence, if objective criteria for diagnosis are not employed, especially in preschool children.

Multiple etiologies for hyperkinesis have been suggested. Either singly or multifactorially, perinatal, psychological, sociological, environmental, and genetic factors, imbalance of neuro-

transmitters, and diet have been implicated.³ Therapeutic endeavors, likewise multiple, are used either alone or in combination. They include stimulant drug therapy, behavior modification, diet restrictions. Drug therapy has included methylphenidate hydrochloride (*Ritalin*, CIBA) or similar compounds, caffeine, and high doses of vitamins. Even changing fluorescent lighting conditions has been tried.⁴ Identification and amelioration of allergies have been suggested as a causative/therapeutic approach.⁵

One of the better known non-medication approaches to therapy is Dr. Feingold's. He contends that 25-50% of children diagnosed as being hyperactive respond to the elimination of artificial food colors and flavors, all salicylates, etc.—the so-called Kaiser-Permanente (K-P) diet.⁶ Employing such a regimen, however, provides multifactorial influences: 1) There are obvious nutritional changes in just staying within such a diet; 2) there is altered social interaction within the family unit, especially for those parents who are desperately looking for a remedy plus the child who is made aware that he is different; 3) such a diet may have a placebo effect; and 4) there is an incidental altered intake of food chemicals other than artificial flavors and colors just by the employment of the K-P diet.

Thus to evaluate the K-P diet as a therapeutic modality, a minimum scientific design would have to include a placebo control group, a double-blind study, random assignment of subjects to treatment groups, standardized evaluations of scientific measuring devices with a degree of reliability and validity, carefully maintained dietary records including infractions, and finally appropriate statistical analysis.

Over the past several years such studies have been undertaken. Their sophistication in design has improved with each succeeding year, overcoming the criticism that the initial studies were

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not adequately controlled nor blind. Dr. Harley and his group at the University of Wisconsin made an extensive study of 46 hyperkinetic children who were randomly assigned to either the K-P or a control diet.^{7,8} Their study, which included crossover of the diets after three to four weeks, included preschool hyperkinetic children as well as non-hyperkinetic "normal" school-aged subjects. During and after the study, three major evaluations were made on each child in addition to a neurological-physical examination: 1) objective neuropsychological evaluations and grid-room observations, including such parameters as locomotor activity, attending to task, general intelligence, memory, motor speed and coordination, reaction time, vigilance, concentration/attention, and academic skills; 2) objective classroom observations made by independent observers; and 3) behavioral ratings using the Conners' questionnaire by the parents and teachers weekly.

Dr. Harley summarized his study by saying: "With the possible exception of a small preschool sample on whom only limited data could be obtained, the overall results do not provide convincing support for the efficacy of the experimental (Feingold) diet. The frequency with which positive diet effects were judged to be present was highest in the subjective parent ratings, declined sharply in the teacher ratings, and essentially disappeared in the objective neuropsychological, classroom, and laboratory observational data . . . Positive effects of the diet were primarily restricted to the sequence of control diet first, experimental diet second—a diet order effect observed in other investigations . . . While there may well exist a subset of hyperactive children whose behavior is adversely affected by artificial food colors, the results of the present study of boys aged six to twelve suggest that such a subset is either very small and/or that the relationship of diet manipulation to behavioral change is much less dramatic and predictable than has been described in anecdotal reports."

A subsequent study was conducted in Canada by Williams et al, who were interested in determining the relative therapeutic effectiveness of dietary (K-P) and drug (stimulant) manage-

ment of hyperkinesis in school-aged children.^{9,10} An additional component to be studied involved determining any possible interaction between the K-P diet and medications. There were 28 children in the study, all of whom had been receiving stimulant medications for at least three months prior to starting the study. None were following the K-P diet until they were placed on it for one month prior to the initiation of the study. The children were then randomly exposed to the following treatment conditions, each lasting one week: 1) *stimulant* medication plus K-P diet with *control* cookies (control diet); 2) *stimulant* medication plus K-P diet with *challenge* cookies (challenge diet); 3) *placebo* medication plus K-P diet with *control* cookies; and 4) *placebo* medication plus K-P diet with *challenge* cookies. Conners' questionnaires were used for behavioral ratings by the parents and teachers.¹¹ On the basis of both parents' and teachers' ratings, drugs were found effective in reducing levels of hyperactivity. Findings on the effect of diet were ambiguous, showing minimal effects in the parents' scores although significant diet effects were noted by the teachers, *but only* when the children were on placebo medication. The results, although suggestive of the possible efficacy of diet control, were felt to be inconclusive.

Subsequently, in 1977 Conners conducted two double blind challenge trials using synthetic food dyes since there had been a controversy in previous parent/teacher ratings as to whether the offending dyes' action was of quick but short duration.¹² The first trial yielded suggestive evidence that performance on a visual-motor tracking task may be impaired after ingestion of challenge material. Three dye-sensitive children were subsequently re-tested in the laboratory, the results yielding evidence consistent with an impairment of attention and visual motor tracking at one hour after challenge cookie ingestion, but not at two or three hours after ingestion. Parent and teacher ratings could not detect the presence of dyes compared with placebo. Conners' second study showed significant effects on parent ratings when the ratings were limited to a three-hour period immediately following ingestion of the challenge cookies, suggesting that artificial food dyes may indeed act to impair and disrupt behavior of the children tested.

Special Reports

The study by Harley and his group is the most rigidly controlled and comprehensive to date.⁸ Strict criteria for admission to the study were employed: 1) No stimulant medications were used at all; 2) dietary control and compliance were controlled by dieticians who made weekly home visits, the entire family's food supply being provided by the study team, including supplementary foods for special occasions; 3) the experimental diet was given for four weeks with an intervening two-week control period; 4) parents, teachers, and graduate psychology students rated the children; and 5) the teachers and graduate psychology students also rated additional children who were not part of the study, thus not only obscuring the identity of those being studied but also providing a means of evaluating the evaluators themselves.

Forty-six children entered the study, 36 between the ages of six and 12, the other ten between the ages of three and six. Teachers and special observers could detect no difference in the children's behavior when on the special diets compared with control diets. Thirteen of 36 mothers and 14 of 30 fathers in the school-age group scored their children less active on the experimental diet, while six mothers and three fathers rated their children more active.

Those interested in some of the latest published reports on the study of hyperkinesis (including studies on behavior modification and a private clinician's opinion that the "entity" is purely related to intra-family psychological dysfunction, especially in terms of handling anger), are referred to the studies by O'Leary and Pel-

ham,¹³ Miller,¹⁴ Williams et al¹⁰ and Harley et al.⁸

For parents having to cope (and survive) with a truly hyperactive child, I hope that they may find relief through the use of one or more of the various therapeutic regimens available, albeit whatever scientific evidence is lacking for its supposed efficacy. Sometimes the "art of medicine" brings greater relief, and sooner, than waiting for medicine's scientific data sheets.

WARREN R. JOHNSON, M.D.

An excellent summary, *Hyperkinesis and Food Additives: A Review of Experimental Work* by Thomas J. Sobotka, Division of Toxicology, was published in *FDA Bylines*, No. 4, January, 1978. I have leaned heavily on Sobotka's review in the preparation of this report; those desiring a more extensive list of references are directed thereto. A copy is on file in the *Delaware Medical Journal* office. W.R.J.

REFERENCES

1. Cantwell DP (Ed): *The Hyperactive Child: Diagnosis, Management, Current Research*. New York, Spectrum Publications, Inc, 1975.
2. Wender P: *Minimal Brain Dysfunction in Children*. New York, Wiley-Interscience, 1971.
3. Safer DJ, Allen RP: *Hyperactive Children: Diagnosis and Management*. Baltimore, Maryland, University Park Press, 1976.
4. Ott JN: Influence of fluorescent lights on hyperactivity and learning disabilities. *J Learn Disabil* 9:417-422, 1976.
5. Wunderlick RC: *Allergy, Brains, and Children Coping*. St. Petersburg, Florida, Johnny Reads, Inc, 1973.
6. Feingold BF, German DF, Braham RM, Simmers E: Paper presented at the Annual Meeting of the American Medical Association, New York, 1973.
7. Harley J, Matthews C: *The Wisconsin Hyperkinesis Study—How it all ended*. Annual Meeting, Wisconsin Food Research Institute, Madison, Wisconsin, 1977.
8. Harley J, Ray R, Lawrence T, Eichman P: *Hyperkinesis and food additives: testing the Feingold hypothesis*. *Ped* 61: 818-827, 1978.
9. Williams J, Cram D, Tausig F, et al: *Determining the relative effectiveness of dietary and drug management of hyperkinesis: a preliminary report of findings*. Working Paper Series, Health Care Research Unit, University of Western Ontario, July, 1976.
10. Williams J, Cram D, Tausig F, Webster E: *Relative effects of drugs and diet on hyperactive behaviors: an experimental study*. *Ped* 61:811-817, June, 1978.
11. Conners C: *A teacher rating scale for use in drug studies with children*. *Am J Psychiat* 126:886-888, 1969.
12. Conners C, Goyette C, Petti T, et al: *A challenge test of diet-responsive hyperkinetic children with artificial colors*. Preliminary Report, 1977.
13. O'Leary SG, Pelham WE: *Behavior therapy and stimulants with hyperactive children*. *Ped* 61:211-217, 1978.
14. Miller JS: *Hyperactive children*. *Ped* 61:217-223, February, 1978.

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Editorials

THE MECHANISM OF CHEMICAL INDUCTION OF CANCER: AN HYPOTHESIS

When I read of the millions of dollars already spent on cancer research and the planning to spend millions more, and equate this largesse with the paucity of information as yet at hand on the mechanism of induction of cancer, I am reminded of two stories.

The first is of a young man who, in the early nineteen twenties, bought a new Essex roadster. After he had obtained a driver's license, he decided to visit a friend some two hundred miles away. Armed with all the necessary emergency equipment and the road maps provided by the local motor club, he set out. All went well until he came to a village with a single, wide unpaved street which divided into roads going west and east but with no direction sign. None of his maps helped him. He called to an old man dozing on a chair in the shade, and asked the way to X. The old fellow said, "Son, that's easy. At the end of the street you turn right, drive about a mile and then turn right again and go straight ahead."

The driver was about to start his car when the old man called out, "Wait; that's wrong. You turn left at the end of the street and drive about a mile and a half. Then you turn left."

The old man scratched his head and said, "Son, if I were going to X, I wouldn't start there from here."

The second story is Edgar Allen Poe's "Purloined Letter." An important secret document was lost, and all attempts to find it failed. If it fell into the hands of enemies, a serious international conflict might ensue. Secret Service agents and police forces stopped and examined all persons leaving the country, but with no success. At the eleventh hour a parlor maid, dusting her employer's office, found the letter in his letter rack, tucked behind advertising material which he had never taken down to read.

Although in the early days of cancer research much attention was given to the study of the

chemistry of coal tar products associated with induction of skin cancers in chimney sweeps and cotton spinners, very little attention has been paid during the last 25 years to a possible chemical mechanism of cancerogenesis.

Cancer research, now a very lucrative business, has been mainly controlled by pathologists and, recently, by epidemiologists. However worthy these two specialties may be, they can hardly be considered dynamic. The pathologist is limited to the study of tissue changes which happened in the past, how far in the past depending on his method of fixing tissues, his staining techniques, and the resolution of his apparatus for microscopy. The epidemiologist, also, is limited to past events recorded with unknown accuracy and completeness. To a great extent, he is tempted to apply the fallacious argument "post hoc, ergo propter hoc" and to use a mathematical method of analysis based on "pure chance" rather than one based on "unequal liability" although the latter accords more with the variations of health in human populations.

The fact that all living tissue conforms to physical/chemical laws has been overlooked, like the "Purloined Letter," in the smokecloud of arguments, around interpretations by this or that authority of what he saw through his microscope. I am presenting here, in simplest terms and with illustrations which clarify a complex matter, a theory of induction of carcinoma by chemicals, a theory based solely on physical/chemical principles, which conforms to all of the important facts and hypotheses on record and which is, above all, subject to relatively easy testing.

The cell of any tissue is a chemical factory, carrying out hundreds of operations, by the use of catalysts (enzymes), and a complex system of membranes which take active parts in all processes. The healthy cell carries out its work with little waste of energy. Excess energy developed in one chemical reaction is used to activate the next.

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To reinforce this energy-conserving faculty of the cell, each cell or group of cells is equipped with an insulating layer, the basement membrane.

Chemically, the basement membrane is a complex of sugars, including glucose. It thus resembles cellulose. Like cellulose, the basement membrane is a good insulator against heat loss. It plays the same part as the materials, often containing cellulose, which we are urged to put in our homes to conserve energy. And everyone knows, particularly the poor, how useful a few sheets of a daily newspaper can be on a very cold day to reinforce thin clothing or to replace the glass of a broken window.

Protected by the economy of its own operations and its insulating basement membrane, the cell goes about its work with little variation in its internal temperature. Yet there are minute energy leaks, and in the course of time the temperature level falls to a point at which, as in a heating system for a home, a "thermostat" set by the genetic pattern of the cell switches on the

mechanisms of mitosis, cell division, and development within each cell of the "furniture" (organelles, membranes, etc.) with which daughter cells can carry on the same processes as the mother. The daughter cells are protected by their insulating basement membrane.

The carcinogens are organic chemicals. All of those originally found to cause carcinoma are products of high temperature treatment of coal. Many of the synthetic organic chemicals which cause cancer in exposed workers are purified derivatives of coal tar. The carcinogens have survived intense exposure to high temperatures. It is logical to assume that to survive they must possess a high ability to conduct heat, or to absorb heat, or both. To be active carcinogens, they must be able to "soak" into the cellulose-like chemical structure of the basement membrane. A well-known example is the effect of dropping mineral oil on paper; the opaque paper becomes translucent, and its ability to transmit light is changed.

Among the more recently recognized carcinogens are the contents of tobacco smoke. These also are products of high temperatures. These also will be absorbed by paper.

The co-carcinogens are not so well defined as the carcinogens. But some of the most active are produced by heating fats. Again, the possibility of ability to conduct or absorb heat is noted. As to the other property required of a carcinogen, the ability to soak into paper, everyone knows what happens when a spot of hot grease from a serving plate splashes onto the best wallpaper in the dining room.

CARCINOGENESIS

The Period of Induction

When a carcinogen having the properties which we have described reaches a basement membrane, it spreads upon it and its molecules mix intimately with the complex carbohydrate molecules of that membrane. This results in a weakening of the insulating value of the membrane. This weakening may not go so far as to allow escape of sufficient energy from the cell interior to activate mitosis and cell division. This is the "period of initiation;" it may never

go further. Nevertheless, the insulating membrane has a defect and may be more easily damaged by other substances, as well as carcinogens.

The Period of Development

If another quantity of a carcinogen reaches the basement membrane—and it need not necessarily be the same as the “inducer”—the insulating quality of the membrane is still further impaired. This time the damage may be great enough to allow appreciable loss of energy, as heat, and the lowering of the intra-cell temperature may be sufficient to instigate mitosis and cell division. This event would occur earlier than would be expected if the basement membrane were completely efficient. Repeated or continual action of the carcinogen would lead to such periodic loss of heat that the intervals between mitoses, cell divisions, and organization of the new cells could become too short for complete cell differentiation.

It requires little imagination to realize that repeated cell divisions in a short time period could lead to formation of a papilloma, and continuation of this process must eventually result in a mass of cells of varied ages, the oldest being fully developed, and the youngest barely separated from its sister. At this stage a microscope slide might show more than one mitotic figure in a single field since all the cells, new and old, for which the damaged basement membrane served as insulation would have been subject to the control of the genetic “thermostat.”

It should be noted that this proposed mechanism of carcinogenesis by chemicals involves no direct injury to genetic material. If in the course of piling up new cells injury to that material should occur, it would be due to inadequate nutrition of the cell as a whole and not to chemical toxicity.

This purely physical/chemical process of cancer formation is quite amenable to testing. Infrared absorption and coefficients of conductivity of heat can be measured for any chemical incriminated in cancer production. Further, there now exists a mass of results of animal experiments which could be assayed from this new viewpoint.

A different point of view on therapy would then be necessary. If mitosis and cell division are initiated by a genetic thermostatic control, it might be possible to eliminate or modify it. The congenital abnormalities produced by Thalidomide suggest suppression of cell division and cell differentiation. A study of the details of the mechanism involved might be a point of departure for cancer therapy.

This hypothesis that the induction of cancer by chemicals results from impairment of the insulating ability of the basement membrane which then allows unusual lowering of intra-cellular temperature and premature and abnormally frequent activation of a “thermostatic” control of mitosis and cell division, could have a wide application to the problems of cancer research.

The details of cell structure, including the placement, composition, and insulating efficiency are, of course, genetically controlled. So also are the range of permissible intra-cell temperature and the “setting” of the “thermostat” which

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Editorials

activates onset of mitosis. As with other factors genetically planned, it may well occur, in the course of generations, that placement, composition, and efficiency of the insulating membrane may be abnormal in one or two individuals. These would then be liable to produce, under adequate provocation, tumors where none had been noted previously.

This theory would explain the ability of cancer researchers to develop by repeated inbreeding strains of mice and rats which develop cancers of a stain-specific type or site on very slight provocation or develop multiple tumors after a single injection of one chemical.

It might also throw some light on the phenomena reported as "Familial Liver-Cell Adenoma and Diabetes Mellitus" by Foster, Donohue, and Burman in the August 3, 1978 issue of *The New England Journal of Medicine*.

This hypothesis would apply also to some of the problems of metastases. When as the result of an abnormal rate of mitosis and cell division, new cells begin to accumulate, some may break

loose from the main body and migrate via lymphatics or blood vessels to other tissues. They carry with them their own genetic pattern of insulation, intra-cell temperature ranges, and thermostatic control, which differ significantly from the corresponding values of the "host" tissue. If the genetically enforced values of the invading cells produce a frequency of cell division greater than that of the host cells, new growth will thrust aside the cells of the host. If, later, the tumor acquires a blood supply of its own, the host tissue will be killed.

I would emphasize that all the events logically deduced from my hypothesis take place without damage to genetic mechanisms. On the contrary, they occur because the cells involved are meticulously "following orders."

They occur as a logical result of physical/chemical interference with distribution of intracellular energy between useful energy, applicable to the ordinary cell metabolism, and energy lost through faulty cellular insulation.

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Book Reviews

THE LIVING HEART by Michael DeBakey, M.D., Antonio Gotto, M.D., David McKay Company, Inc., New York, 1977. 256 pp. Illus. Price \$14.95.

Michael DeBakey is the most renowned cardiovascular surgeon in the country. He and his co-author, Antonio Gotto, have put together a very readable book about the cardiovascular system aimed at appealing and selling to the general public. The literary style is enjoyable. There is an abundance of good quality illustrations, the type is quite legible, and a glossary of medical terms is included. All this should contribute to the popularity of the book.

The scope of the text is broad. It includes a short review of the medical history of the cardiovascular system, its basic physiology, congenital abnormalities, coronary artery disease, stroke, hypertension, pacemakers, cardiovascular surgery, and, of course, aneurysms. It is filled with interesting trivia, such as, the "... volume of blood pumped by the average heart during a person's lifetime would fill a cylinder twenty-four feet in diameter to a height taller than the Empire State Building." It also contains information of practical knowledge for the people affected by these diseases, ie, the importance of treating hypertension and of coronary heart disease recognition and prevention. Since cardiovascular disease is so prevalent and the leading cause of death in this nation, it is a topic of much interest and concern.

In summary, it is a well-written book for the layman. It will please its authors by being a good seller, and it will both entertain and educate its readers about a most important subject.

JAMES ANTHONY TRUAX, M.D.

✻ ✻ ✻

INTERPRETATION OF BIOCHEMICAL MULTITEST PROFILES by Paul L. Wolf, M.D., Masson Publishing USA, Inc., New York, 1977. 296 pp. Illus. Price \$19.50.

There has been considerable criticism of multi-channel biochemical screening over the past few years. Many abnormalities on SMA-12/60 or

similar screens are found to be minor or uninterpretable; and, while unsuspected disease may be revealed, the lack of an understanding of the natural history of the disease often makes early diagnosis of questionable value. On admission biochemical profiling may be desirable in order to establish baseline data since subsequent diagnostic or therapeutic procedures may well serve to change these results.

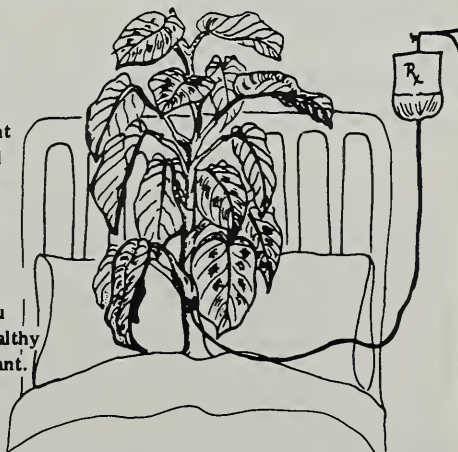
Dr. Wolf, a prolific writer in the field of laboratory medicine, has brought together one hundred multitest panels and correlated these with the patient's history and physical findings. In all these cases the patient had symptoms, and often the diagnosis is apparent from the history and physical examination. The author illustrates his book with copies of the SMA 12/60 or 6/60 strip charts which have normal values shaded in and other diagnostic information superimposed. The reader is encouraged to recognize patterns in the abnormalities demonstrated. While pattern recognition is useful and amenable to computerization, it is easy to be misled into believing that

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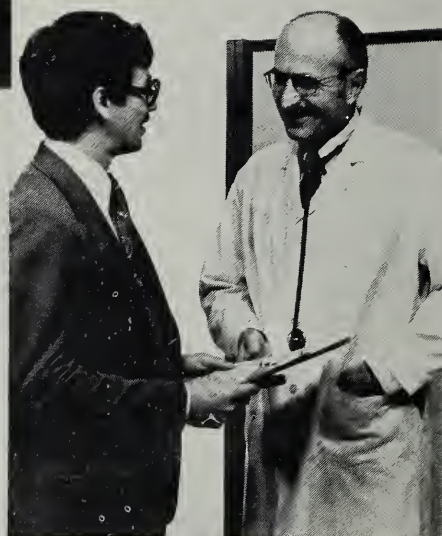
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a certain pattern may be identified with a specific diagnosis. Rarely or never are the patterns that specific, and it is more important to look at individual results as an aid in confirming or refuting a particular diagnosis.

As an aid in teaching medical students the place of the laboratory in the diagnostic process, this book has its undoubted uses, but I believe that for the practicing physician its usefulness is limited.

P. JOHN PEGG, M.D.



POST-MORTEM EXAMINATIONS AND THE POSITION OF PATHOLOGY AMONG BIOLOGICAL STUDIES by Rudolf Virchow, Scarecrow Reprint Corporation, Metuchen, New Jersey, 1973. 172 pp. Illus. Price \$6.00.

This modest hard-bound book is a facsimile edition of two unrelated works by Rudolf Virchow. The first work is a translation of *Die Sektions-Technik im Leichenhause des Charite-Krankenhauses* (1875) published in 1896 by P. Blakiston of Philadelphia; the second comes from *The Proceedings of the Royal Society of London*, v 53, No 322, 1893. Walter J. Putschar, M.D., of Massachusetts General Hospital introduces the book with brief biographical sketches of both Virchow and William Croone, for whom the Honorary Lecture of the Royal Society of London was named.

Virchow begins the first work, *Post-Mortem Examinations*, by criticizing the haphazard style of autopsy procedure at the time he took his job at the Charite. He found a major failing to be the post-mortem's subservience to the pre-mortem history; anatomical defects were searched only to support clinical observations. No attempt was made to systematize an anatomical exploration of the deceased that would stand as an autonomous piece of information. Necroscopy at that time was not much more than sophisticated Roman augury.

The above lamentation is followed by specific remarks on technique, such as the correct order of observation of body structures. Virchow's writing tends to ramble here, including a variety

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of digressions about knife handling. Several of his drawings are included at this point.

The reader is finally relieved with an outline for the sequence of prosection. Anyone who has performed an autopsy will be struck by how little has changed in the past hundred years, including the sensible suggestion of examining the large bowel last. Pathologists still drop a piece of lung taken from a newborn at post into water to test for tissue aeration; a description of this test is also found.

Three post-mortem reports of mainly forensic import which effectively demonstrate the foregoing suggestions are presented. The meticulous descriptions of these dissections give the reader a sense of the literal meaning of the word autopsy, "to see with one's own eyes." Noteworthy among Virchow's omissions is the lack of descriptions of the thyroid and adrenal glands, which can be taken as a reflection of the primitive state of endocrinology circa 1875.

In the final chapter, the work is recapitulated in the form of a prosection outline which could

be used today, including the four-week report deadline. To Virchow, a 19th century politician, the forensic significance of the autopsy equaled or surpassed its medical importance. By integrating his revisions into the legal machinery of Germany, Virchow ensured the rapid acceptance of his format, with obvious benefits to medicine.

In his Croonian lecture, Virchow traced the development of pathology in a weighty, philosophical style, with particular references to English and German contributions. This culminates with a reference to his own doctrine of "Omnis cellula a cellula."* The style of the dissertation is typical of 19th century German academic writing with its long historical prolegomena and its brief contemporary closing addendum.

JEAN COBLENTZ

*Freely translated, "All cells come from cells."

Ms. Coblentz is a senior medical student at Jefferson Medical College.



PULMONARY MEDICINE by Clarence A. Guenter, M.D. and Martin H. Welch, M.D., J. B. Lippincott Company, Philadelphia, 1977. 829 pp. Price \$49.50.

This is the single best volume on pulmonary disease that I have read in years. The amount of information crammed into these pages is remarkable. The writing is clear and tight and without excess verbiage, and this is true across the board. This is a tribute to the editing by the two principal authors and to their careful selection of a small group of exceptional contributors.

In any textbook there is a direct relationship between its usefulness and the ease in retrieving information. Information as represented in the numerous tables and charts in this book makes it very useful for either spot checking or for more detailed reading. The references are voluminous and up-to-date, a number as late as 1976.

The book is divided into two major parts. Part I—titled "Introduction to Respiriology"—is divided into sections on the Respiratory Environment, the Respiratory Airways, Ventilatory Function of the Lungs, and Respiratory Function of

the Lungs and Blood. This includes effects of variations in atmospheric conditions, a concise section on evaluations of the patient with ventilatory dysfunction, and a very useful section on arterial blood gases and their use in assessing the overall adequacy of lung function.

Part II, which comprises the major portion, includes chapters on Acute Respiratory Failure, Acute Infectious Respiratory Illness, Chronic Respiratory Tract Infections, Pulmonary Vascular Disease, Chest Trauma, Pleural Disease, Abnormalities of the Chest Wall, Chronic Non-Infectious Parenchymal Diseases, Obstructive Diseases, and Neoplastic Diseases.

If you would like to know about intermittent mandatory ventilation or concentration of inspired oxygen using various modes of delivery or pleural dynamics, there are clearly labeled diagrams for reference. If you are interested in defense mechanism of the respiratory tract, opportunistic infections of the lung, the effects of upper abdominal surgery on lung function, or emission of pollutants from gasoline engines, there are charts on these subjects and a host more.

This book is highly recommended for all internists, chest physicians, and thoracic surgeons. Almost all other primary care physicians will find this a useful reference source.

LEONARD P. LANG, M.D.



HYPNOTIC REALITIES: THE INDUCTION OF CLINICAL HYPNOSIS AND FORMS OF INDIRECT SUGGESTION by Milton H. Erickson, Ernest L. Rossi, and Sheila I. Rossi, Irvington Publishers, Inc., New York, New York, 1976. 326 pp. (includes cassette tape) Price \$23.50.

This book attracted me because Milton Erickson is renowned for his work in both clinical and experimental hypnosis. In actuality, the book seems mostly to have been put together by co-author Ernest Rossi, based on tapes of training sessions Erickson had conducted with him and on tapes of conversations and comments made by the two of them when discussing events of other

training sessions and general points about hypnosis.

Much of the book consists of transcriptions of these training sessions, with the discussions of them interpolated. This makes the book less than easy to read, and useful assimilation of its contents requires rereading.

This is a good book for the hypnotist or the become adept at using the various techniques which are dealt with in each chapter although many of the exercises seemed nonspecific to me. A cassette tape which comes with the book is merely a recording of most of the first chapter. Its only real use seems to be for one to hear Erickson's voice in an actual hypnotic session.

This is a good book for the hypnotist or the would-be hypnotist, but I feel it would also be interesting and useful to the vast majority of physicians who never will hypnotize a patient in that it gives good insight into such things as what makes people follow suggestions or, in our current medical jargon, "patient compliance."

One final thing about the book—it is loaded with typographical errors. I wonder if the proof-reader went into a trance while on the job?

ROBERT H. HALL, M.D.

❖ ❖ ❖

MONITORING IN ANESTHESIA edited by L. J. Saidman, M.D. and N. T. Smith, M.D., John Wiley & Sons, Inc., Somerset, New Jersey, 1978. 355 pp. Illus. Price \$25.00.

Monitoring In Anesthesia is a multi-authored text, edited by Saidman and Smith. Its title is somewhat misleading, however, for although it was written from the viewpoint of monitoring anesthetized patients, much of the information in this book is applicable to the care of any critically ill patient.

The first two chapters do deal with changes in the body produced by general anesthesia. Chapter One is an abbreviated overview of assessing depth of general anesthesia, while the second chapter deals with assessment of some of the biochemical changes associated with general anesthesia.

The section on monitoring of respiratory function during anesthesia was limited, and rather superficial. In contrast, the chapters on the cardiovascular system are very well presented. Methods of cardiovascular assessment are well covered, and the limitations of various monitoring techniques such as systolic time intervals are presented.

The chapter on neuromuscular blockade should be useful to any physician treating patients who have received this type of drug. The chapter on monitoring the obstetrical patient should also be of value to those caring for patients during labor and delivery. Monitoring of the neurosurgical patient is another very well written section. The pathophysiology of cerebral function is first discussed, and then specific intraoperative considerations are presented.

A recent area of attention has been that of occupational exposure to trace amounts of inhalation anesthetic agents, and the chapter by Whitcher presents the state of the art to date in this field. The following chapter on monitoring in the recovery room deals adequately with a vast topic.

The remainder of the book focuses attention on areas of electrical safety, choosing appropriate electrical equipment, the computer's role in acute care medicine, and finally future trends. These, again, are subjects which should be of interest to all physicians dealing with critically ill patients.

Overall, the book is well written and provides a wealth of information concerning a wide spectrum of critical care areas.

RICHARD N. HINDIN, M.D.

❖ ❖ ❖

A PAEDIATRIC VADE-MECUM, 9th ed, edited by Ben Wood, D.M., F.R.C.P., Year Book Medical Publishers, Chicago, 1977. 203 pp. Price \$8.50. Paperback.

This book is widely appreciated in Britain and three other European countries . . . by hard pressed house persons . . .," according to

Book Reviews

the foreword. A small volume measuring about 7.5 by 5 inches and 200 pages, the *Vade-Mecum*, which roughly translated means "go with me," is designed to "fit snugly into the pockets of . . . white coats." As such, it is the European equivalent of the *Harriet Lane Handbook*, to which it must be compared.

A chapter on normal development included a chart of epiphyseal union ages along with line drawings, which were interesting but not of much use. The milestones and physical parameters at given ages were equivalent in both books, but more cumbersome in the *Vade-Mecum*. The section on nutrition was overinvolved with eponymic diets, and many of the preparations mentioned are not available here. Fluid and electrolyte therapy was set aside on different colored pages. The author used calories/kilogram method, although his maintenance replacements were higher than those commonly used

here. The short chapter on the neonate seemed adequate. Charts of infectious diseases included incubation periods and were helpful at times. Chapters on emergencies and poisoning were quite adequate and to the point, as if the author did expect one to consult those pages before proceeding. Chapters entitled Clinical Chemistry, Paediatric Prescribing, Antibiotic and Chemotherapy, and Corticosteroids were all marred in their usefulness by different lab values, formulations, and preparations from those that pertain here in the US.

This volume cannot be recommended for anyone who plans to consult it in a clinical setting in our medical community, but it is of interest to those who enjoy comparing notes with someone who practices differently, but no less effectively.

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Deaths

NIZAR KUSEYBI, M.D.

Nizar Kuseybi, M.D., aged 44, died Sunday, June 25, 1978, at Beebe Hospital, Lewes, Delaware, after suffering a heart attack at his Rehoboth Beach home.

Dr. Kuseybi was born in Koms, Syria, January 2, 1934. Upon completion of his elementary and secondary education in Koms, he enrolled in the Faculty of Medicine at the Syrian University in Damascus, Syria. He received his Doctor of Medicine Degree in June, 1959, and upon graduation he entered the United States to continue his medical education.

His internship and first year residency in obstetrics-gynecology were spent at Huron Road Hospital, East Cleveland, Ohio, 1959-1961. He was assistant resident and resident in obstetrics-gynecology at Maryland General Hospital in Baltimore, 1961-1963, and was a fellow in obstetrics-

gynecology at South Baltimore General Hospital, 1963-1964.

He received his license to practice medicine and surgery in January, 1964 from the Maryland Board of Medical Examiners, and after joining the Beebe Clinic in Lewes in September, 1964, he began his practice there. He was actively engaged in the practice of obstetrics and gynecology and had established a large practice during his nearly 14 years' service in this area, until the time of his death.

Dr. Kuseybi was elected President of the Sussex County Medical Society and served in 1972. He was also a past President of the Medical Staff of Beebe Hospital.

Dr. Kuseybi is survived by his wife, Janice, and three children, of Rehoboth Beach; a brother, Kamal Ksebe, M.D. of Lewes, Delaware; and also numerous relatives in Syria.

CHARLES M. BANCROFT, M.D.

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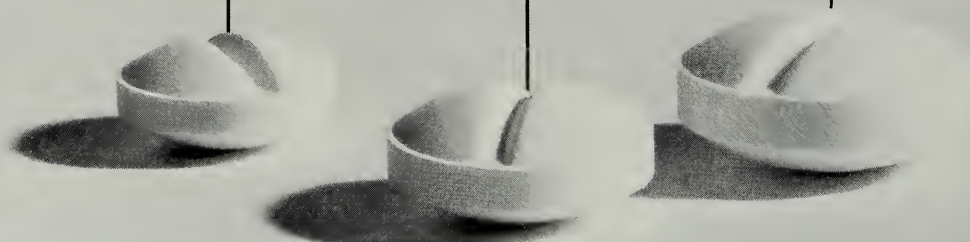
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In Brief

Speakers on "Ask the Doctor"

Speakers for October 1978 on the Tuesday radio program (11:05 a.m., WDEL) produced by the Medical Society of Delaware are: October 3, *Gerald J. Savage, M.D.*, Spinal Anesthesia; October 10, *Howard A. Lovett, Jr., M.D.*, The Emergency Medical System; October 17, *Irving K. Berkowitz, D.O.*, Breast Cancer and Chemotherapy; October 31, *Fred C. Hausler, Jr., M.D.*, Anesthesia in General, but Not Necessarily General Anesthesia.

Call for BP Abstracts

The National Conference on High Blood Pressure Control is seeking papers that address problems and approaches to the detection, treatment, and long-term management of the hypertensive patient. Papers should describe research related to clinical practice, innovative treatment programs, provider and patient compliance, state, community, and primary care programs, economics, and psychological and social aspects of hypertension. Evaluation of the roles of various health care providers and organizations and the hypertensive care of minorities, employees, the elderly, children, and the family are also encouraged. Abstracts must be postmarked by October 25. The Conference will take place April 4-6,



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1979, The Washington Hilton, Washington, D.C. For information contact: National Conference on High Blood Pressure Control, 1501 Wilson Boulevard, Suite 600, Arlington, Virginia 22209.

Conference on Libraries and Informational Services

The Wilmington Area Bio-Medical Library Consortium (WABLC) has been established by 14 educational, hospital, and other health-related institutions in the Wilmington area to share library and information resources, help with reference questions, and provide a forum for information-sharing and problem-solving. WABLC will take part in the DELAWARE GOVERNOR'S CONFERENCE ON LIBRARIES AND INFORMATIONAL SERVICE, October 19-21, Sheraton Inn, Dover, Delaware. They will have a continuing slide presentation and a visually coordinated reference section using a Medline terminal. Through the Mid-Eastern Regional Medical Library Service at the College of Physicians of Philadelphia, WABLC provides access to the entire health sciences information field of the National Biomedical Communication Network. Contact the Delaware Academy of Medicine for more information. Telephone: 656-1629.

Dr. Robert O. Y. Warren Memorial Seminar

The Dr. Robert O. Y. Warren Memorial Seminar will be presented at the Delaware Academy of Medicine on November 10. Guest faculty will consist of Andrew M. Margileth, M.D., Children's Hospital, Washington, D.C.; Irving J. Olshin, M.D., Jefferson Medical College; and David B. Schaffer, M.D., Children's Hospital, Philadelphia. Elmer F. Fantazier, M.D., Calvin B. Hearne, M.D., and

Henry H. Stroud, M.D., all of Wilmington, will moderate round table discussions. Registration is limited to the first 150 applicants. The Seminar is acceptable for 5 CME hours for the Physician's Recognition Award of the AMA and for the American Academy of Family Physicians. For registration information contact the Delaware Academy of Medicine. Telephone: (302) 656-1629.

CLINICAL NOTICES AND MEETINGS

American Heart Association Program

The American Heart Association of Delaware will present the following program. For information contact: American Heart Association of Delaware. Telephone: (302) 654-5269 (Wilmington); 856-7386 (Georgetown); (302) 734-9321 (Dover).

ADVANCED CARDIAC LIFE SUPPORT PROVIDER COURSE, October 13-14, Henlopen Hotel, Rehoboth Beach, Delaware.

Cancer Seminars

The American Cancer Society and the Delaware Cancer Network will co-sponsor a seminar, **CANCER: WHAT IT IS AND WHAT IT IS NOT**, 8:15 a.m. to 3:30 p.m., October 13, Brandywine Hilton Inn, Naaman's Road, Wilmington. The program will provide an educational review of cancer for helping and health care professionals. For information contact: Jayne Fernsler, ACS, (302) 654-6267; Barbara Letang, DCN, (302) 428-2113.

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Care of the Dying

The American Cancer Society, the Delaware Cancer Network, and the Department of Family Practice, Wilmington Medical Center will hold a two-part meeting, **CARE OF THE DYING: IS HOSPICE NECESSARY?**, October 30. The first part of the program, at the Academy of Medicine, Wilmington, 9:00-11:00 a.m., is open to the public and all health professionals. Robert S. Brown, M.D., of St. Paul, Minnesota, will be the featured speaker. From noon-1 p.m. all health professional are invited to attend the Department of Family Practice meeting at the Memorial Division Auditorium, Wilmington Medical Center. For information contact: Jayne Fernsler, R.N., ACS, (302) 654-6267.

ACP Meetings

The following meetings, which fulfill Category I requirements for the AMA Physician's Recognition Award, will be presented by the American College of Physicians.

SOUTHEASTERN REGIONAL MEETING, October 27-28, Savannah Inn and Country Club, Savannah, Georgia. For information contact: Nicholas E. Davies, FACP, 35 Collier Road, N.W., Atlanta, Georgia 30309.

NEW JERSEY REGIONAL MEETING, November 8, College of Medicine and Dentistry of New Jersey, Rutgers, New Jersey. For information contact: Norval F. Kemp, FACP, Perth Amboy General Hospital, 530 New Brunswick Avenue, Perth Amboy, New Jersey 08861.

WESTERN PENNSYLVANIA AND WEST VIRGINIA REGIONAL MEETING, November 10-11. For information contact: John B. Hill, FACP, 465 Woodland Hills, Pittsburgh, Pennsylvania 15235.

Care of the Elderly

The George Washington University Medical Center will host **CURRENT CONCEPTS IN CARE OF THE ELDERLY**, October 27, Washington, D.C. The program meets CEU and CME criteria for credit. For information contact: Nona Boren, A.C.S.W., Director,

In Brief

Gerontology Program, GWU Medical Center, 2300 Eye Street, N.W., Washington, D.C. 20037. Telephone: (202) 676-3721.

American College of Chest Physicians Meeting

The American College of Chest Physicians will host the 44th ANNUAL SCIENTIFIC ASSEMBLY, October 29-November 2, Washington Hilton Hotel, Washington, D.C. The program meets the criteria for 30 credit hours in Category I of the Physician's Recognition Award of the AMA. For information contact: Dale E. Braddy, M.S., Director of Education, American College of Chest Physicians, 911 Busse Highway, Park Ridge, Illinois 60068. Telephone: (312) 698-2200.

Emergency Medicine Seminar

The EIGHTH ANNUAL SEMINAR ON ADVANCES IN EMERGENCY MEDICINE will be held on November 2-3, Cherry Hill Inn, Cherry Hill, New Jersey. For information contact: John P. Salvo, M.D., Box 41, Medford, New Jersey 08055. Telephone: (609) 757-3830.

Critical Care Conference

The Fairfax Hospital will present the Third Annual Symposium on the Care of the Critically Ill Patient: THE MANAGEMENT OF SERIOUS INFECTIONS, November 18, George Mason University Lecture Hall, 4400 University Drive, Fairfax, Virginia. The program is approved for 8 hours in Category I toward the Physician's Recognition Award of the AMA. Approval has been requested from the AAFP. For information contact: Donald M. Poretz, M.D., FACP, Symposium Program Director, The Fairfax Hospital, 3300 Gallows Road, Falls Church, Virginia 22046. Telephone: (703) 698-3219.

VA Research Review

The Veterans Administration Center will present the FIFTH ANNUAL RESEARCH REVIEW SEMINAR, November 21, 9:30 a.m.-12:00 noon, eighth floor Conference Room, Veterans Administration Center, 1601 Kirkwood Highway, Wilmington. The medical community is invited to attend. For information contact: Henry R. Cowell, M.D., Associate Chief of Staff for Research and Development, VA Center, (302) 994-2511, Ext. 266.

Terminal Care Seminar

The Post-Graduate Board, Royal Victoria Hospital and McGill University will sponsor the SECOND INTERNATIONAL SEMINAR ON TERMINAL CARE, November 2-4, Queen Elizabeth Hotel, Montreal, Canada. The Seminar is designed for physicians, nurses, social workers, chaplains, therapists, administrators and others involved in the provision of terminal care. English and French are the official languages of the Seminar, and simultaneous translations will be available for all presentations. The program is approved for Category I credits by the American Academy of Family Physicians. Applications will be accepted in order of receipt until October 9. For information contact: Balfour M. Mount, M.D., Program Director, Post-Graduate Board, Royal Victoria Hospital, 687 Pine Avenue West, Montreal, Quebec H3A 1A1. Telephone: (514) 842-1321, local 264.

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cancer communiqué

FROM THE DELAWARE CANCER NETWORK*

NUTRITIONAL SERVICES PROGRAM

SUSAN R. SHONE, R.D.
THOMAS C. FEDEWA, Ph.D.

The primary goal of the Nutritional Services Program at the Delaware Cancer Network is to ensure that optimal nutritional care is provided to all cancer patients in the State of Delaware. The nutritional component of comprehensive multidisciplinary cancer management services is the latest addition to the Network's cancer control effort. The task in this area is a large one because of the comparative newness of the renewed efforts in studying the links between cancer, patient management, and nutrition. This renewed effort is immediately evident in the review of all cancer literature, whether this be in basic or applied research as well as in the literature relating to patient management.

Within the past ten months, the immediate objectives of the Network's Nutritional Services Program have been established, and work has started to implement the program. These objectives include professional and public education and will also focus on patients and their families. Initially, opportunities are being provided whereby interested professionals can visit other institutions as a springboard to more actively working together in nutrition and cancer.

The ten Network-affiliated hospitals have been defined as the initial targets for the most aggressive education. The beginning of the educational efforts in these hospitals will focus on working with local personnel in the areas of assessment of the nutritional status of the cancer

patients, instruction in the latest assessment techniques in recording the assessment findings, and the development of a local program to insure constant review and updating of the techniques as well as ways of using the findings. In line with this, objective methods of determining a patient's nutritional status are being defined, and a form for recording this information has been developed. It is hoped that a common form will be able to be put in use in all hospitals in the State by the end of the current program year. In this way, there will be a common nutritional assessment base created for all cancer patients in the State. Appropriate professionals in all ten targeted hospitals are now receiving education in the use of these nutritional measures and the charting of the data.

Educational efforts have also included a trip to the Fox Chase Cancer Center in Philadelphia to see how a nutritional support team operates and how a nutritional assessment program can be implemented. It is hoped that a similar trip to the Crozer-Chester Medical Center can be arranged in the near future. Any professionals who would be interested in participating in such a program should contact the Nutritional Coordinator's Office at (302) 428-2114. It is hoped that the educational efforts can include hearing about as well as seeing and doing the new nutritional assessment techniques.

A second program goal is to extend the use of these nutritional assessment techniques in the tumor clinics. To date, there has been no significant nutritional risk for malnutrition. Another

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target of outpatient nutritional educational efforts will be the participants in the various cancer patient self-help groups in the State. These groups are a natural focus of nutrition concerns ranging from need for suitable alternative meals to instruction in proper use of nutrition supplements.

A third goal will be set in place, a Network-sponsored program as part of the Coordinated Undergraduate Program in Dietetics for students from the University of Delaware. Initially, a group of dietetic students will be spending part of their community nutritional affiliation working with Network staff. Network staff presentations have been made part of the ongoing curriculum for students at the University. It is anticipated that two students will be working at the Network for four weeks during the Spring Semester. If this arrangement proves beneficial, it is hoped that this program can be continued in the coming years.

Finally, Network-sponsored nutritional publications have been developed or are being planned for both professionals and the public. A section on the dietary management of the breast cancer patient has been completed for the Network's *Guidelines to Breast Cancer Management*. A similar piece has been started for the *Colo-Rectal Management Guide*. Both are available by contacting the Network Office. Plans for public education include the publication of the following: a high roughage diet guide for patients with constipation; a high protein, high calorie guide; a booklet on liquid diet specifically geared towards head and neck cancer patients; and a recipe booklet by cancer patients for cancer patients. These latter publications would be especially helpful for patients and the professional community. It is anticipated that other publications will be forthcoming as the need arises or as new information becomes available.

If the adage stating that we are what we eat is true, then there is an increased concern for the cancer patient who is not only at higher risk for malnourishment but who also needs specialized diet because of the nature of the disease and the therapies involved in combating the same.

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CONTRAINDICATIONS Hypersensitivity to oxycodone, aspirin, phenacetin or caffeine.

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DOSAGE AND ADMINISTRATION Dosage should be adjusted according to the severity of the pain and the response of the patient. The usual adult dose is one tablet every 6 hours as needed for pain.

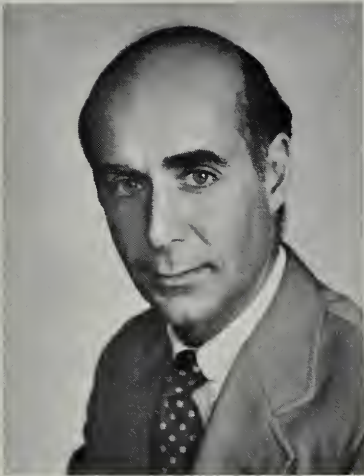
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President's Page

VOLUNTARY EFFORTS

The Carter Administration continues its efforts aimed at mandatory control of hospital costs and revenues. This is despite the fact that, in Delaware, as well as nationally, the rate of increase in hospital costs for 1978 has been significantly reduced from previous years. This reduction has come about by a Voluntary Effort, nationally, as well as locally. For the first six months in 1978, Delaware's eight, not-for-profit, short-term community and specialty hospitals have held their overall rate of increase in total expenditures to 9.12%. The goal was to reduce the 14.04% rise in 1977 to 12% in 1978; as of June, 1978, this goal has not only been met but also exceeded.

The Voluntary Effort was officially started in Delaware in January, 1978. A committee was formed composed of representatives from the Medical Society of Delaware and the Association of Delaware Hospitals. Prior to this, in October, 1977, discussion had already been initiated on ways the Medical Society could cooperate with the hospitals in Delaware in voluntarily containing costs. The major goals of the Voluntary Effort include the 2% reduction per year over the next two years, with no net increase in the number of beds and a restraint of new hospital capital investment.

While this effort has achieved praiseworthy results, there are aspects that must be closely watched. We must never lose sight of the fact that the patient's welfare is our primary concern. Restraint of new hospital capital investment, if

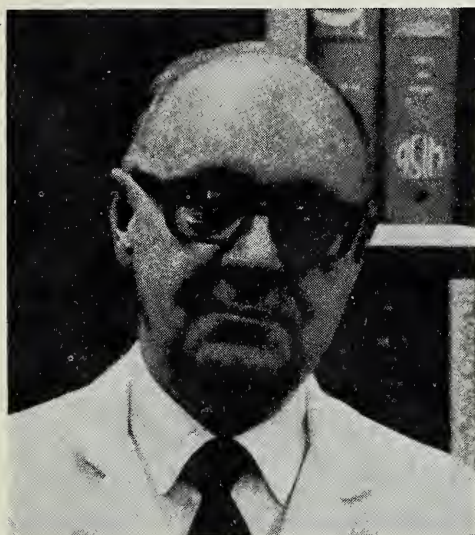
carried out over a period of years, could lead to delays in replacing outmoded and worn-out equipment, delays in necessary modernization of existing facilities, and, eventually, a deterioration in a quality of health care as we now know it.

Even more ominous is the creation of a permanent lid on capital expenditures as proposed by HEW. This would place a dollar limit on expenditures per year, with Washington controlling where the expenditures would go. This would, of course, be contrary to our present method of local planning and approval of capital expenditures, and would replace it with a federally controlled bureaucracy to regulate expenditures.

The successful efforts of the Voluntary Effort have gained much credibility and respectability for the American Hospital Association in Washington. We physicians could well learn from this Voluntary Effort. Listen and pay heed to Dr. Tom Nesbitt, President of the American Medical Association, regarding voluntary restraint in the rise of physicians' charges. We can use and benefit from the credibility that could be established in such a voluntary action by us now.

"THE PHYSICIAN IS A DECISION MAKER, AND ALMOST EVERY DECISION HE MAKES COSTS OR SAVES MONEY."

—Dr. William Felts, Past President,
American Society of Internal Medicine



More and more physicians today are beginning to realize the extent of the economic influence they have, and are finding ways of holding costs down.

A number of studies show that the more physicians *know* about costs, the more they try to *reduce* them.* And this reduction can be done without reducing the quality of care to the patient.

How are they doing this? As a start they have become thoroughly familiar with the costs they incur on behalf of their patients. They know how much an X-ray costs, how much their

hospital charges for routine lab tests. They're requesting copies of patients' hospital bills. And asking their hospitals to print the charges for diagnostic tests right on the order sheet.

What else are physicians doing? Minimizing their patients' hospital stays, whenever possible. Reevaluating routine admissions procedures. Questioning the real need of the diagnostic tests they order for their patients. Avoiding duplicate testing. Trying to discourage their patients' demands for unnecessary medication, treatment or hospitalization. Compiling daily logs of their medical decisions and what they cost. And more.

More physicians today realize what a tough problem we're all faced with. They know this is a challenge for medicine. And that physicians are in the best position to deal with and solve the problem.

*PATIENT CARE Magazine—Outlook 1977, "Face-Off: Cost Containment vs. Chaos," January 1, 1977.

Lyle CB, et al. "Practice habits in a group of eight internists," ANNALS OF INTERNAL MEDICINE 84 (May 1976), 594-601.

Schroeder SA, et al. "Use of laboratory tests and pharmaceuticals: variation among physicians and effect of cost audit on subsequent use," JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 225 (Aug. 20, 1973), 969-73.



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ATTITUDES OF NONPARTICIPATION TOWARD THE SWINE INFLUENZA IMMUNIZATION PROGRAM IN SOUTHERN DELAWARE

NORFLEET W. RIVES, JR., PH.D.
ANNE MOONEY, PH.D.

Introduction

Following a relatively short but turbulent history, the National Influenza Immunization Program was suspended by the federal government on December 17, 1976. From the very beginning of the program earlier the same year, it was clear that a mass immunization effort on this scale would test both the capability and the credibility of federal, state, and local public health organizations. Concerns were expressed about prospects for developing safe and effective vaccines in adequate supply and about the manner in which the vaccines might be most effectively distributed to the target populations. In addition, questions arose about the extent to which persons injured by the vaccine might recover damages and the extent to which the entire immunization program was founded in election-year politics.

Many persons have undoubtedly by now forgotten that public health officials feared the

possibility of a major influenza epidemic. But the swine flu immunization program should not be casually dismissed because there are valuable lessons to be learned from this experience, lessons involving both the health education of the American population, and the available organization for the mass distribution of any preventive health service.

The unprecedented scale of the swine flu immunization program meant that medical service would have to be provided to a wide range of population groups. Persons living in nonmetropolitan urbanizing areas, such as Kent and Sussex Counties, the two southern counties of Delaware, have traditionally experienced problems obtaining primary health care. Many of the smaller towns and cities in the United States are nonmetropolitan areas where the elaborate system for the delivery of medical services found in larger population centers is not available. It is relevant to ask how effectively the swine flu immunization program performed in these areas. To what extent did the characteristics of the program determine its fate? In what manner was the program subject to the health attitudes and behaviors of local populations? The purpose of this paper is to address these two issues,

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This paper, in a slightly different form, was presented at the 105th Annual Meeting of the American Public Health Association, November 1977.

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focusing on the responses of a sample of persons living in a nonmetropolitan, urbanizing area who decided not to participate in the government-sponsored program.

Methodology

The information presented in this paper was developed from responses to a survey questionnaire administered on an interview basis during the late fall of 1976.* The sampling frame for the survey was the household population of Kent and Sussex Counties.

According to current estimates, the population of each county is on the order of 90,000 persons, about 20 percent of whom are nonwhite. Most of the population resides in rural areas and in small incorporated places.

The survey represents an area probability sample of 412 households drawn from updated

*It is important to note that the sole purpose of the survey was not the collection of information concerning public reaction to the swine flu immunization program. Much of the questionnaire was devoted to family attitudes and experience with public and private health and social services for children and youth. Swine flu questions were added to the survey instrument because the timing of the survey provided a unique opportunity to assess the local impact of a controversial national program.

census listings and divided almost evenly between the two counties. Vacant units, refusals to participate, and unusable questionnaires reduced the effective sample size to 375.* Field operations for the survey extended from early November through the second week in December.** The final interviews were completed just several days prior to suspension of the swine flu immunization program so there is the possibility that the anticipated suspension of the program may have affected the responses of persons interviewed late in the survey, but, in any event, the number of cases in this category is small.

Sample Description

Tables 1 and 2 present the respondent, household, and contextual characteristics for the 375 cases discussed in this report. These three sets of characteristics represent variables relevant to the study of health behavior and attitudes. Respondent characteristics include age, sex, ethnicity, and educational attainment. The household characteristics surveyed were the source of income of head of household and housing tenure.*** Contextual characteristics involved the perceived convenience, in terms of distance and hours of operation, of doctors' offices, emergency rooms, and hospitals.

The characteristic frequency distributions presented in both Tables 1 and 2 have been weighted by the number of persons aged 18 and over in each household. The column labeled "sample size" gives the number of respondents in each category, while the columns labeled "weighted responses" and "weighted percent" give the absolute and relative frequencies weighted by adult household size or, more pre-

*The overall level of survey nonresponse on subject items selected for analysis in this paper is 0.5 percent. Since this figure is quite small, allocations for nonresponse were considered unnecessary.

**All interviews were conducted by trained enumerators from the College of Urban Affairs and Public Policy at the University of Delaware, the principal contractor for the survey project. Statistical analysis conducted on selected questions indicated no significant interviewer effects.

***It should be noted that source of income was used rather than amount of income because the latter variable, when it was asked for, produced a disappointingly high, yet predictable, level of nonresponse. The source variable is not a perfect substitute for the amount variable, but in this particular study the former is actually quite useful. If we were interested in the ability of households to pay for a certain service, then having information on amount of income might be relatively important; however, there was no charge for the swine flu immunization. Furthermore, our interest is focused more on the measurement of the socioeconomic standing of households in the larger community, and source of income represents one dimension of socioeconomic rank.

Attitudes of Nonparticipation Toward the Swine Influenza Immunization Program—Rives

TABLE 1

RESPONDENT AND HOUSEHOLD CHARACTERISTICS OF THE
BASIC SWINE FLU IMMUNIZATION SAMPLE, SOUTHERN
DELAWARE SURVEY: 1976

Characteristic	Sample Size	Weighted ¹ Responses	Weighted ¹ Percent
Total Sample	375	833	100.0
Sex			
Female	315	697	83.7
Male	60	136	16.3
Ethnicity			
White	311	685	82.2
Nonwhite	64	148	17.8
Age			
18-24	49	99	11.9
25-34	144	289	34.7
35-44	115	272	32.6
45-54	50	133	16.0
55 +	17	40	4.8
Education			
Grades 1-8	30	76	9.1
Grades 9-11	78	177	21.3
High School Graduate	176	385	46.2
Some College	57	119	14.3
College Graduate	31	71	8.5
Postgraduate Training	3	5	0.6
Source of Income of Head of Household ²			
Wage or Salary	275	N/A	73.4
Self-Employment	44	N/A	11.7
Pension	24	N/A	6.4
Public Assistance	11	N/A	2.9
Other	14	N/A	3.7
Not Earner	7	N/A	1.9
Housing Tenure ²			
Own or Buying	267	N/A	71.2
Rent	108	N/A	28.8

¹ See text for discussion of weighting procedure.

² Responses are not weighted; percents are not weighted.

TABLE 2

CONTEXTUAL CHARACTERISTICS OF THE BASIC SWINE FLU
IMMUNIZATION SAMPLE, SOUTHERN DELAWARE SURVEY: 1976

Characteristic	Sample Size	Weighted ¹ Responses	Weighted ¹ Percent
Convenience of Doctor's Office			
Distance			
Yes	325	727	87.3
No	42	89	10.7
DK *	8	17	2.0
Hours of Operation			
Yes	318	712	85.5
No	49	104	12.5
DK	8	17	2.0
Convenience of Emergency Room			
Distance			
Yes	320	710	85.2
No	46	103	12.4
DK	9	20	2.4
Hours of Operation			
Yes	344	767	92.1
No	21	44	5.3
DK	10	22	2.6
Convenience of Hospital			
Distance			
Yes	336	749	89.9
No	38	82	9.9
DK	1	2	0.2
Hours of Operation			
Yes	359	802	96.3
No	15	29	3.5
DK	1	2	0.2

¹See text for discussion of weighting procedure.

*DK designates "Don't Know."

cisely, the reciprocal of the response selection probability.¹

According to Table 1, the sample contains a disproportionately large number of female respondents, an outcome not wholly unexpected from daytime surveys conducted in predominantly rural areas. The age, ethnicity, and education distributions are much more representative; and the household characteristics, income source and housing tenure also compare quite favorably with updated census estimates.

The contextual variables were included in the survey on the assumption that perceived convenience of health services, expressed in terms of hours of operation and distance, influences service utilization. When compared with the distribution of population, the distribution of physicians, emergency rooms, and hospitals in the study area is such that one would not expect significant differences among responses to the convenience questions by any given respondent. Thus, respondents who found doctors' offices convenient in terms of hours of operation and distance were also very likely to have found emer-

gency rooms and hospitals convenient. Furthermore, most respondents found each service convenient enough. This pattern of response is generally apparent in the six sets of weighted frequency distributions in Table 2 and provides a basis for collapsing these distributions into broader categories for further analysis.

FINDINGS

Extent of Participation

The first question addressed by the survey analysis was the extent of respondent participation in the immunization program. Table 3 shows that only 23 percent of the population had been immunized at the time of the survey. Almost half of the respondents, 48 percent, were nonparticipants without plans to participate, (here called definite nonparticipants). Among the other nonparticipants, about half volunteered their intention to participate, and the others did not know whether they would or not.

Since health-related behaviors are known to vary by the characteristics of the individual and his/her social context, we explored whether par-

TABLE 3

PARTICIPATION IN THE SWINE FLU IMMUNIZATION
PROGRAM, SOUTHERN DELAWARE SURVEY: 1976

Characteristic	Weighted ¹ Responses	Weighted ¹ Percent
Participant	192	23.1
Nonparticipant		
Plans to participate	110	13.2
Does not plan to participate	400	48.0
Does not know	131	15.7

¹See text for discussion of weighting procedure.

TABLE 4

PARTICIPATION IN THE SWINE FLU IMMUNIZATION PROGRAM,
BY SELECTED RESPONDENT CHARACTERISTICS, SOUTHERN
DELAWARE SURVEY: 1976

(deviations from total sample percents)

Characteristic	Participant	Nonparticipant		
		Plan	No Plan	DK
Ethnicity				
White	4.0	0.4	-2.9	-1.5
Nonwhite	-19.1	-1.7	13.5	7.3
Age				
18-24	-13.0	10.0	5.6	-2.6
25-34	-0.3	0.0	2.2	-1.9
35-44	5.6	-1.5	-6.8	2.7
45 +	-1.1	-3.4	4.0	0.5
Education				
Less than high school	-12.0	-2.9	6.5	8.4
High school graduate	0.3	3.4	-3.1	-0.6
More than high school	14.9	-2.9	-2.4	-9.6

participation in this program also varied by respondent characteristics. Sex made little difference in the levels of participation. Three other characteristics—ethnicity, age, and educational attainment—did make a difference; these findings are shown in Table 4. To facilitate comparison and analysis, the percentages in this table as well as in several other tables are expressed as deviations from the corresponding sample totals.

Whites, who dominated the sample of respondents, differed little from the total distribution in the extent of their participation. Nonwhites were less likely to be participants and more likely to be nonparticipants than the average of all respondents.

The categories of age and education were collapsed in Tables 4 and 6 to increase the raw totals to a size appropriate for reliable percentages.* The most interesting age group is the youngest; those aged 18-24 were less likely than older respondents to have participated in

the program and more likely to plan to participate. High school graduates were similar to the average for all respondents; but those with less than a high school education were less likely to have been immunized, and those with at least some college education were more likely to have been immunized. Thus participation, in general, was higher among the better educated, and lower among nonwhites, the youngest, and the least well-educated. These results correspond to the usual experience with participation in preventive health programs.

Home owners were not unusual in their rate of participation, but renters were less likely to be participants and more likely to be definite nonparticipants. The few respondents living in households inconveniently located with respect to health facilities had about six percent more definite nonparticipants than the average; those who did not know about the convenience of facilities were likely to be nonparticipants with intentions to participate. Some of these categories involve very few respondents.

*All respondents over age 45 were combined in one category, and educational attainment was reduced to three levels: those with less than 12 full years of schooling, high school graduates, and those with more than a high school education.

Reasons for Nonparticipation

The second question addressed by the analysis involves the reasons for failure to participate among the definite nonparticipants, ie, the group who had not participated and were not planning to do so. The answers to the question about why nonparticipants were not planning to be immunized were coded into four categories, labeled ADVICE, FEAR, BELIEF, and PROGRAM. (Table 5) The first group, ADVICE, which encompassed 15 percent of the nonparticipating respondents, included persons allergic to eggs, pregnant, or with other illnesses and conditions which made immunization contraindicated. Also included here were respondents who said that their physicians had advised against immunization, but gave no more specific reason. It is possible that some of these physicians were generally opposed to the program, but we have no information about that.

More than a third of the definite nonparticipants gave FEAR as their reason for staying out of the program. Most of them did not elaborate, but among those who did there were general expressions of fear, such as "I don't like needles,"

as well as concern about side effects or other fears related to the vaccines being used. The third category of reasons, BELIEF, was the largest of the four, accounting for 36 percent of the nonparticipating respondents who had a reason. Included here are such responses as "I don't need it," "I don't believe in it," "I never get sick," "I've always been healthy," and "I'll take my chances."

More specific responses about the swine flu program itself were coded in the fourth category, PROGRAM, which accounted for 15 percent of nonparticipants. Their responses included concern about the credibility of the program and the reliability of the vaccines, such as "too much controversy" and "bad publicity." Some respondents were more direct and called the program a hoax or an attempt by drug companies to realize larger profits. These respondents expressed suspicion and mistrust of the program and its aims, as opposed to the respondents in the previous categories, who tended to exempt themselves from participation but who did not express any negative views about the program as a whole. These responses are im-

TABLE 5

REASONS FOR NONPARTICIPATION IN THE SWINE FLU
IMMUNIZATION PROGRAM, SOUTHERN DELAWARE
SURVEY: 1976

Reason	Sample Size	Weighted ¹ Responses	Weighted ¹ Percent
Advice	24	50	15.0
Fear	47	114	34.1
Belief	53	120	35.9
Program	23	50	15.0

¹See text for discussion of weighting procedure.

TABLE 6

REASONS FOR NONPARTICIPATION IN THE SWINE FLU
IMMUNIZATION PROGRAM, BY SELECTED RESPONDENT
CHARACTERISTICS, SOUTHERN DELAWARE SURVEY: 1976

(deviations from totals for sample of nonparticipants with reason)

Characteristic	Reason			
	Advice	Fear	Belief	Program
Sex				
Female	1.8	-2.7	1.6	-0.7
Male	-9.4	14.0	-8.1	3.5
Ethnicity				
White	1.0	-2.9	2.1	-0.2
Nonwhite	-3.7	11.0	-7.7	0.5
Age				
18-24	10.5	-15.0	0.3	4.1
25-34	-3.4	-1.9	3.8	1.5
35-44	-5.1	3.3	5.9	-4.0
45 +	5.0	8.6	-13.2	-0.3
Education				
Less than high school	2.2	6.9	-5.4	-1.9
High school graduate	-2.5	0.6	4.4	-2.5
More than high school	1.2	-13.5	5.6	8.5

portant to distinguish since individuals who believe they do not need immunization against influenza would probably avoid participating in any program that did not convince them that they did need the vaccine. Additional participants may also be lost from future programs, if the programs are perceived to be dangerous, based on questionable assumptions, or more beneficial to participating organizations than to the general public.

Table 6 shows that differences with respect to the reasons for nonparticipation were found for sex, ethnicity, age, and education. These differences represent deviations of population subgroups from sample totals. Males were more likely than the average nonparticipant to express FEAR and less likely to mention ADVICE or BELIEF. The sex difference in the ADVICE

category may be accounted for by pregnant females who were specifically advised against immunization. Nonwhites were also more likely to mention FEAR and less likely to mention BELIEF. Among the youngest nonparticipants, ADVICE was cited more than usual and FEAR less. On the other hand, among those aged 45 and over, ADVICE and FEAR were more likely to be cited and BELIEF less likely. Those with more than a high school education were less likely to mention FEAR and more likely to cite either BELIEF or PROGRAM.

One household characteristic and one contextual characteristic were important for distinguishing respondents with different reasons for nonparticipation. (Table 7) In households where the primary source of income is transfer payments, that is, public assistance or a pension,

ADVICE was more likely to be cited than in the average nonparticipant household and FEAR was less likely. This may reflect a combination of younger women on public assistance who were pregnant and older people on pensions. This interpretation is only speculation, however, as there were too few cases to allow valid analysis of cross-classified characteristics.

Respondents who found health facilities inconvenient in terms of distance or hours were less likely to cite FEAR as a reason for nonparticipation, but more likely to cite BELIEF. The few who do not know about the convenience of health facilities were less likely than the average nonparticipant to mention ADVICE and more likely to mention BELIEF. The failure to cite ADVICE suggests a general detachment from the health care system to the point where medical advice would not often be sought nor be well received.

Discussion

In order to estimate the extent to which the results of the Delaware survey might have been replicated elsewhere in the nation, we compared

our results with reports of two other surveys, one covering levels of participation nationally, and the other covering reasons for nonparticipation in the New York City area.

In the fall of 1976, the National Center for Health Statistics (NCHS) Health Interview Survey contained questions about the receipt of swine flu shots. Between September 20 and December 19, 19 percent of the total population was immunized.² As the NCHS report points out, however, immunization was not recommended for those under age 17 until late fall, and thus a low level of immunization was found for the population 0-17 years. Among those 18 and over, the population corresponding to those interviewed in Delaware, the level of immunization was about 18 percent in the 18-to-24-year group and about 30 percent in those older. These figures are higher than those for southern Delaware, where only 10 percent of those aged 18-24 and about 24 percent of those over age 24 were immunized.

The NCHS survey showed the level of immunization among whites of all ages to be 21

TABLE 7

REASONS FOR NONPARTICIPATION IN THE SWINE FLU
IMMUNIZATION PROGRAM, BY SELECTED HOUSEHOLD
AND CONTEXTUAL CHARACTERISTICS, SOUTHERN
DELAWARE SURVEY: 1976

(deviations from totals for sample of nonparticipants with reason)

Characteristic	Reason			
	Advice	Fear	Belief	Program
Source of income of head				
Wage, salary, or self-employed	-3.9	1.9	1.9	0.1
Pension or public assistance	19.0	-20.2	-0.8	2.0
Health facility convenience				
Yes	-0.2	0.3	0.2	-0.3
No	4.4	-18.8	13.3	1.1
DK	-15.0	-4.3	13.3	6.0

Attitudes of Nonparticipation Toward the Swine

percent; for all other races it was 7 percent. In Delaware, the rate for adult whites was 27 percent, but for adult nonwhites, only 4 percent. This suggests a greater disparity between white and nonwhite adults in southern Delaware than in the country as a whole, especially considering that the national nonwhite level is deflated by low rates of immunization among persons under 18 who are a relatively high percentage of this group.

It may be that this comparison of levels of immunization shows the difficulties of bringing a program to nonmetropolitan areas like southern Delaware, as opposed to doing so in metropolitan areas, the populations of which account for about 70 percent of the national total and thus dominate national averages. Nonmetropolitan location is not the whole explanation, however, as indicated by other information. For instance, even as early as mid-October, South Dakota and Wyoming, two nonmetropolitan states, had participation levels above 10 percent when most areas of the country were below 1 percent; Wyoming's rate was then nearly 22 percent, higher than the national average at the time the program was suspended.

The experience of New York City also suggests that low rates of participation in nonmetropolitan counties were not because of a general problem of accessibility compared with large cities. A very low rate of participation, 3.5 percent of the adult population, was reported in New York City in mid-November; this was the lowest percentage in the country at the time.³ In fact, it was this low rate of participation that led the Health Department of New York City to conduct its survey.

Among all respondents to the New York City survey, which included both commuters interviewed in Manhattan and residents in city neighborhoods, the majority (52 percent) said the shots were not necessary. This is almost exactly the same percentage as would be obtained by combining the two categories from the Delaware survey labeled BELIEF and PROGRAM. Although we chose to emphasize different dimensions of response in labeling certain answers as health-related beliefs and others as program-related reasons, all BELIEF and PROGRAM responses amounted to the respondents' saying

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Final classification of the less-than-effective indications requires further investigation.

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that the immunization was not thought to be necessary.

Virtually the same proportion (34 percent) of nonparticipants in Delaware and in New York City reported being afraid to get the shots. Physicians' advice accounted for 13 percent of the reasons given in New York City and 15 percent of responses by nonparticipants in southern Delaware. The correspondence between the results of the two surveys is rather remarkable, considering differences in the populations, the survey design and questions, and the independence of the two operations.*

The most important hypothesis we derive from this comparison is that Americans throughout the country are subject to similar stimuli with respect to national activities in the health field such as the swine flu immunization program, and they are likely in the aggregate to have very similar reasons for refusal to participate when they decide not to. Thus, it would appear that similar strategies may be usefully employed for changing beliefs and overcoming fears of citizens in many parts of the country. The main difference to be expected among geographic areas is in the level of nonparticipation, not the distribution of reasons.

Implications

When any public health organization undertakes a program of major scale, involving potentially millions of people, the appearance of the program in the eyes of the public becomes centrally important. From its initial coverage in the national media, the swine flu immunization program seemed to be proceeding under a heavy cloud of expert doubt. The appearance of less than unanimous support for the program from within official circles did not facilitate the selling of the program to others, neither to practicing physicians nor to the general public.

The ADVICE response of nonparticipants provides an indirect indicator of this problem. A detailed analysis of this particular response clearly shows that, although many respondents receiving professional advice were advised not to participate for various specific medical reasons, others gave no definite reason. Some of

these respondents may have been steered away from the program by physicians who doubted the value of the vaccines, questioned the prospects for a swine flu epidemic, or simply mistrusted this intervention into the provision of health care. This interpretation of the evidence from the ADVICE response reflects the extent to which the medical care sector and public health officials had not reached agreement on the utility of this important enterprise.

Without judging whether the attempt to inoculate most of the country's population against an influenza virus is an appropriate public health goal or should be under some circumstances, in order for such a plan to succeed the health-related beliefs of many Americans would clearly need to undergo some change. More than 70 percent of nonparticipants, or 28 percent of the total sample of respondents in southern Delaware, either believed that the flu shots were unnecessary or were afraid to get them. If these are general attitudes toward immunization, as they appear to be from these interview responses, we may assume that such beliefs would influence the success of any future program. Therefore, if physicians are persuaded that mass immunization may sometimes be necessary for effective disease control, then methods of convincing the skeptical public need to be found.

We do not know what approaches would be most effective, but we suggest that steps should be taken to identify and use them before the next occasion arises in which mass immunization is advised. Among the possible approaches, three types of activity seem to be potentially important:

1. Organizational and procedural planning
2. Experimenting with methods for effective disease control
3. Consumer and patient health education

The first type of activity would involve both public and private health care sectors in a coordinated effort to develop plans for the administration and financing of a program, including the production and distribution of new vaccines, and the administration of these vaccines to the public. It is important to have a viable mechanism for the mobilization of resources when the objective is the control of a potential

*The Delaware data were collected and analyzed past the stage of tabulating the reasons for nonparticipation before we became aware of the existence of the New York survey.

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epidemic. The existence of such a mechanism should reduce the likelihood that a program will become mired in disorganization and succumb to official uncertainty and public mistrust.

A second kind of planning effort involves the relationship between individual physicians and their patients. In some specialties such as pediatrics and obstetrics, as well as in dental practice, physicians have developed routines for educating patients in preventive procedures, for setting up appointments on a recommended schedule, and for reminding and following up patients who do not appear at appropriate times. These procedures could be adapted to the practices of physicians whose patients include those most likely to require influenza immunization. Since certain populations at risk are encouraged to obtain influenza shots annually even in non-epidemic years, various techniques could be tried that would help the practicing physician to learn how to insure that patients receive the preventive services they should have. In addition, in the context of the annual physical examination or at some other regular appointment, every physician could make a point of explaining his or her recommendations with respect to immunization and instructions about what to do in the event of a national campaign.

The second type of activity, experimenting with methods for effective disease control, would include identification of the characteristics of populations at greatest risk of complications from influenza, their geographical locations, and usual sources of care, so that it might be easier to reach them when circumstances warrant. Furthermore, attention might be directed to different strategies of disease control, such as the one recently discussed in the *New England Journal of Medicine*, which suggests concentrating an immunization program on those with the highest attack rate who, therefore, have the greatest potential for spreading the disease to others, including those at highest risk of deleterious consequences.⁴

The need to develop effective disease control programs underscores the importance of experimentation in the search for them. The recent WHO smallpox eradication campaign suggests that the most obvious approach from an intuitive

standpoint may not be the best in practice.^{5,6} At first the program pursued a strategy of mass vaccination for smallpox eradication. Experience showed that a different strategy, emphasizing surveillance followed by containment measures, was much more effective. Experience with the swine flu program also strongly suggests that attempts to immunize an entire population in a relatively short time period may be too ambitious. Experimentation with different methods for disease control should help to identify the particular circumstances under which each method produces desired results.

The final type of activity, consumer and patient health education, involves two kinds of effort. The first kind is a mass educational effort concerning the importance of various disease control measures. This includes both measures that should be pursued constantly, such as immunization against certain childhood diseases, and measures that may be invoked only periodically, such as when a new and unusually virulent influenza virus is identified. Mass educational efforts can be carried out in schools, places of work, churches, senior centers, neighborhood centers and clubs, professional organizations, and through the mass media.

The second kind of effort involving health education can be carried on by physicians in their own offices with their own patients. Under these circumstances, when the controversy surrounding a large-scale immunization program is not quite so violent, physicians can answer questions more effectively, they can allay fears, and they can correct misinformation. Discussion of beliefs, fears, and other health-related concerns of the patient may uncover useful information for physicians who want to be prepared to advise and treat their patients effectively in the event disease caused by another influenza virus threatens to reach epidemic proportions.

REFERENCES

1. Kish L: Survey Sampling, p 58. New York, J Wiley & Sons, 1965.
2. US National Center for Health Statistics: Estimates of Flu-Like Illnesses and Flu Shots by Age and Color From the National Center for Health Statistics: September 20-December 19, 1976.
3. New York Times. "New York City Residents Resist Flu Shots and a Poll Learns Why," by R Sullivan. Sunday, November 21, 1976.
4. Glezen WP, Couch RC: Interpandemic influenza in the Houston area, 1974-76. *NEJM* 298:587-592, 1978.
5. No. 283 WHO Expert Committee on Smallpox. First Report, Geneva, WHO, 1964.
6. No. 493 WHO Expert Committee on Smallpox Eradication. Second Report, Geneva, WHO, 1972.

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MANAGEMENT OF BREAST CANCER: LIMITED MASTECTOMY

GEORGE CRILE, JR., M.D.

Introduction

My stand on the treatment of breast cancer has been widely misunderstood. Many surgeons believe that I advocate what the British call "lumpectomy" and irradiation. Nothing could be further from the truth. I do, however, stand firmly against the traditional radical mastectomy. I consider it to be archaic, and I believe that it has no place in the modern treatment of breast cancer.

I strongly support modified radical mastectomy. It is indicated primarily for a patient who has palpable involvement of a few low or central axillary nodes at the time of operation. If the involvement is extensive, however, and particularly if the nodes at the apex are palpably involved, I agree with Haagensen¹ that the apex of the axilla should not be dissected. It is better to rely on irradiation alone to control the cancer in the apical, supraclavicular, and internal mammary nodes, because the combination of complete axillary dissection and irradiation is apt to result in severe lymphedema of the arm.

The Question of Axillary Dissection

In patients who have no palpable involvement of axillary nodes at the time of operation, I think there may be an advantage, immunologically, in not removing or irradiating the nodes, but this point is unproved. The advantage, if any, in long-term survival is small. Therefore, the modified radical mastectomy with low and central axillary dissection is an acceptable method in all cases in which there is no palpable evidence of axillary involvement, and it has the advantage of giving precise information about the extent of nodal involvement so that a decision can be made about giving chemotherapy.

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"Lumpectomy" vs Partial Mastectomy

I have never used lumpectomy as a treatment of breast cancer. The term suggests a sort of excisional biopsy that could not be effective unless one wished to rely on irradiation as part of the primary treatment. Some surgeons in this country advocate this procedure, notably Cope et al,² but the morbidity after irradiation is higher than that following modified radical mastectomy. Partial mastectomies, in which the skin overlying the tumor, a wide segment of breast tissue, and the fascia under the tumor are removed, are good operations in properly selected patients, ie, in those with small, peripheral tumors that are not multicentric. Until recently these constituted only 11% of all of our operations, but with increasing experience and confidence this has been increased to about 20%.

See editorial comments on page 570.

Total mastectomy is always better than partial because it eliminates the possibility of new cancers forming in the affected breast. From the surgeon's standpoint, total mastectomy is also easier than partial mastectomy, which involves plastic reconstruction of the breast. Modified radical mastectomy also reduces the incidence of secondary operations, so that from the standpoint of both surgeon and patient, total mastectomy involves less worry and follow-up care. For these reasons, I prefer total mastectomy. Bilateral mastectomy has similar advantages over unilateral.

The only problem with mastectomy is that many women view the loss of both breasts, or even the loss of one, as a disaster. Today, it is fear of this loss rather than failure to understand the significance of a lump that is the greatest cause of delay in treatment. For this reason and because, in properly selected cases

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patients who are treated by partial mastectomy have just as high survival rates at both five and ten years as those treated by radical mastectomy, I believe that the patient should have something to say about the selection of treatment.

When women know that the deformities and disabilities of radical mastectomy are no longer necessary, and when they have learned that many small, localized, and peripherally located cancers can be treated by partial mastectomy, I believe that they will seek treatment earlier and will benefit from a higher rate of permanent cure.

The Results of Controlled Trials

The following is a list of the controlled trials that have tested the results of various treatments of breast cancer. In none was any difference in survival noted at five or at ten years.

1. Forrest, APM, et al.³ Simple mastectomy and axillary biopsy—irradiation if nodes are involved vs Radical mastectomy—irradiation if nodes are involved.
2. Kaae, S & Johansen, H.⁴ Superradical mastectomy vs Simple mastectomy and irradiation.
3. Brinkley, D & Haybittle, JL,⁵ Simple mas-

tectomy and irradiation vs Radical mastectomy and irradiation.

4. Burn, Ian.⁶ Simple mastectomy vs Simple mastectomy and irradiation.
5. Hamilton, T et al.⁷ Radical mastectomy vs Simple mastectomy and irradiation.
6. Murray, JG.⁸ Clinical Stages I and II. Simple mastectomy alone vs Simple mastectomy and irradiation.
7. Wise, L, Mason, AY, and Ackerman, LV.⁹ Radical mastectomy with or without irradiation vs Partial mastectomy with or without irradiation.
8. Peters, Vera.¹⁰ Radical mastectomy and irradiation vs Local excision and irradiation.
9. Hayward, John (Sir Hedley Atkins).¹¹ Radical mastectomy and irradiation vs Wide local excision and irradiation.*
10. Crile, George, Jr.¹² Partial mastectomy with or without irradiation vs Total mastectomy with or without axillary dissection and irradiation.

From the above studies it is clear that there is nothing new in the concept that operations less than radical mastectomy are as effective as the radical. It is just that surgeons in the United States have been slow to recognize it.

Analysis of Ten-Year Survival Rates

In recent years, supporters of the simplified treatment of breast cancer have been challenged by Haagensen¹ and Anglem and Leber,¹³ who contend that although the survival rate at five years may be satisfactory after less than radical operations, the longer-term survival rates are much worse. They base their comparisons on a few reports of phenomenally high ten-year survival rates after radical mastectomy. If one reads the original articles, however, it is apparent that these high survival rates are based on (1) age-adjusted or "definitive" survival rates, in which deaths from causes other than cancer are not counted; (2) survival rates of patients who were treated by radical mastectomy, but excluding patients who because of age, infirmity, or advanced cancer were not considered suitable for radical operation; (3) series of cases wherein

*Early results in Stage II with only a few patients available for ten-year follow-up showed advantage for radical mastectomy, but with passage of time, the results seem to be equalizing.

a method of staging was used, in which patients with advanced disease were not included, or in which they were excluded on the basis of biopsy of involved apical or internal mammary nodes, or, (4) the results obtained in a private, referred surgical practice rather than those of an entire institution.

The figures quoted by Anglem and Leber¹³ for ten-year survival rates are sometimes as much as 16% higher than those usually reported by other surgeons doing standard radical operations and by the Public Health Service's Report *End Results in Cancer, 1972*.¹⁴ This publication consists of the survival rates at five and ten years compiled from the tumor registries of the states of Connecticut, Massachusetts, and California, and from six university hospitals.

The ten-year survival rate of the registry patients with Stage I and II cancer was 43%. The vast majority of the patients described were treated by radical mastectomy. The ten-year survival rate of the Cleveland Clinic cases that I have reported has been almost identical (46%), yet fewer than 1% had radical mastectomies. The same proportion of patients in each group had Stage I cancer, 53% and 52%, respectively. The five-year survival rate of the "inoperable" Stage III and IV patients also was the same, 12% and 11%. (Table 1) It is clear, therefore, that with cancers in the same stage, radical mastectomy conferred no benefit in terms of long-range survival. (Tables 1 and 2) The ten-year survival rate after radical mastectomy reported in the huge National Surgical Adjuvant Breast Project trial conducted by Bernard Fisher and his

TABLE 1

Cleveland Clinic

Treatment of Operable Stage I or II Cancer,
1957-1965 (Inclusive)

	Patients	
	No.	%
True Stage I		53*
True Stage II		47*
Invasive cancer**	(438/453)	98
Modified radical mastectomy**	(220/453)	45
Simple mastectomy	(178/453)	42
Radical mastectomy	(4/453)	1
Partial mastectomy***	(51/453)	11
Cobalt therapy postoperatively	(96/453)	21

*Since all axillae were not dissected these are estimates based on (1) those whose axillae were dissected, (2) those who were not irradiated and had appearance of cancer in nodes, and (3) a projection from above data of the probable incidence in those patients with clinically involved axillae which were treated by irradiation.

**If in situ cancer is not included, the proportion of survivors remains the same.

***Included are five patients who had axillary dissection.

associates was limited to patients less than 70 years old, but the ten-year survival was almost identical to that of the Cleveland Clinic, 45.9% vs 46%.¹⁵

Technique Has Little Effect on Survival

The ten-year survival rates reported by Haagensen¹ and Anglem and Leber¹³ are so much higher than those attained by most surgeons doing similar radical mastectomies that they can hardly be explained on the basis of better technique. Haagensen, for example, has said that in terms of survival, the results obtained by his

TABLE 2

Comparison of Survival

Cleveland Clinic and Cancer Registry
1957-1961 (Inclusive)

Stage of Cancer	Cancer Registry Treated by Radical Mastectomy (%)	Cleveland Clinic Treated by Less than Radical Mastectomy	
		No.	%
Inoperable Stage III and IV lived 5 years	12	(14/122)	11
Operable I and II lived 5 years	61	(502/710)*	71
Operable I and II lived 10 years	42.8	(209/453)	46
Operable I and II lost and counted dead	**	(11/453)	3
Local recurrence	**	(27/453)	6

*1957 thru 1970 inclusive

**No information given

TABLE 3
Survival of Patients with Occult Cancer in Nodes
After Various Types of Treatment

Years Survived	Simple Mastectomy,* No Irradiation (Nodes Dissected Later and Found to Be Involved)		Immediate Modified Radical Mastectomy** (Nodes Thought to Be Uninvolved but Pathologist Found Cancer)	
	No.	(%)	No.	(%)
5	18/24	(75)	18/28	(64)
10	8/24	(33)	8/28	(29)

*11/28 (39%) had 3 or more nodes involved.

** 8/24 (33%) had 3 or more nodes involved.

Table 3 is reproduced with permission of *Annals of Surgery* (18:26-30, 1975).

residents are just as good as his own. Moreover, it isn't likely that differences in the way nodes are treated could have much effect on survival, for it can be calculated that even if the axillary nodes were not treated at all, fewer than 10% of the patients would die solely as a result of spread from axillary metastases. Yet Haagensen and Anglem attribute their 16% higher survival rate to more thorough removal of nodes.

But no one would leave involved nodes untreated. If the nodes were involved palpably, either they would be removed by axillary dissection or they would be irradiated. Several of the above-mentioned randomized studies have shown that the survival rates are the same regardless of the method chosen.

After the Primary Tumor Is Removed, Delay in Treating Occult Cancer in Nodes Does Not Affect Survival

What if nodes are palpated, with the axilla open, and are not palpably involved? Is there a risk in doing only a simple mastectomy and giving no treatment to the nodes until the occult cancer in them becomes palpable? The answer is no. At both five and ten years, our patients who had occult cancer that was not treated until it become palpable in the nodes (average, 22 months), did just as well as patients in similar stages who were treated by immediate axillary dissection but the pathologist found microscopic cancer in nodes. (Table 3) Also, in spite of the delay, the number of involved nodes in the two groups was the same. Nothing was lost, therefore, by delaying axillary dissection until the involvement of nodes was palpable. A randomized study in England has shown the same thing (see Trial No. 6).

Is There Increased Risk in Partial Mastectomy?

A retrospective, randomized, matched-pair study in which the cases were matched for size of tumor, presence of invasive cancer, and involvement of nodes showed a slight advantage for partial mastectomy over total mastectomy in terms of five-year survival rates.¹² At ten years, there still was little difference in survival. More patients had died of cancer in the group that was treated by radical operations than in the group treated by simple ones, 36% and 32%, respectively, of the 50 patients in each group. (Table 4)

The incidence of local recurrence ten years after simple operations was only 6%,* much less than after radical operations in most reported series. This, we believe, is because in radical operations the combination of lymphadenectomy and the cutting of the thin-skin flaps traps cancer cells in the lymphatics of the skin and also because injury to the blood supply of the skin promotes the growth of the cancer cells.^{5,6} In partial mastectomies, on the other hand, there is no lymph stasis and no vascular damage to the skin. (Table 4)

Multicentricity

Although it is true that careful sectioning of the breast shows microfoci of cancer in about half of the cases, it is also true that many of these foci are adjacent to the tumor and would be removed by the type of partial mastectomy that I recommend. It also is true that 25% of women who have cancers in one breast have microfoci in the other.¹⁶ It is recognized that

*In cases in which the axilla was neither dissected or irradiated the first appearance of cancer in axillary nodes is not considered to be a recurrence because the area never had been treated.

37% of all men over 50 years of age have micro-foci of prostatic cancer¹⁷ and that 6% of all Americans¹⁰ and 18% of all Japanese¹⁸ have microfoci of cancer in their thyroid glands. In short, in older people, if you look hard enough for microfoci of cancer, you can find them almost anywhere. The question is, do they develop into true cancers? The answer is, rarely.

The incidence of cancer in the contralateral breast has been reported to vary from four to seven per 1,000 patient-years of exposure.¹⁹ Slack and his associates in the National Surgical Adjuvant Breast Project concluded that although cancer did occur more frequently in women who had had a cancer of one breast, deaths from the new cancers were so rare that negligible protection would be given by removing the contralateral breasts routinely.²⁰ The same appears to be true about removing the rest of the homolateral breast after partial mastectomy.

A total of 132 of our patients who were treated by partial mastectomy have been observed for a few months to as long as 18 years. The average period of follow-up is a little more than five years. This gives more than 700 patient-years of follow-up. There have been four cancers involving breast tissue on the side of the partial mastectomy, and six on the contralateral side. Unless there is a strong family history of breast cancer or unless there is cancerophobia and a desire to be rid of the breasts, there would seem to be little more reason to remove all of a breast for a small, localized, and peripherally located tumor than to remove both breasts.

Informed Consent

Every surgeon has his own beliefs about how

he likes to treat breast cancer, but, if pressed, I think most of us would have to agree with Bernard Fisher, one of America's foremost experts on breast cancer, who has said that we simply don't know what is the best treatment (oral communication, 1974. Am. Coll. Surgeons Meeting). It seems to me, therefore, that surgeons are obligated to inform their patients that there is no proof as to which treatment is best. Certainly, if women were informed of the deformity and disability that may attend radical mastectomy, and if they also were told that randomized studies had shown that it had no advantage over simpler procedures, few if any would accept it.

Partial mastectomy is a little different. I think a surgeon is justified in advising against partial mastectomy for the reasons stated in the beginning of this article. But if a woman has a tumor suitable for treatment by partial mastectomy and if she is reluctant to lose her breast, I do not believe that a surgeon is justified in telling her that a partial mastectomy would seriously jeopardize her expectancy of survival. In Stage I cancer, the results of Peters²¹ and of Atkins and Hayward¹¹ after local excision and irradiation show as high a survival rate at ten years as was obtained by radical operations and irradiation. As an acknowledgment of these findings the National Cancer Institute recently has authorized a randomized study comparing the results of modified radical mastectomy with those of partial mastectomy with axillary dissection and irradiation. This study is now being conducted by Dr. Bernard Fisher in the National Surgical Adjuvant Breast Project. The National Cancer Institute would not have authorized

TABLE 4
Matched* Pair Study 1957-1965 (Inclusive)

	Partial Mastectomy	Total Mastectomy
Average number nodes +	5	4
Average age	56 years	53 years
Cobalt	12/50	18/50
Local recurrence	4/50 (8 %)	5/50 (10 %)
Lived ten years	22/50 (44 %)	27/50 (54 %)
Died other causes	10/50 (20 %)	5/50 (10 %)
Died of cancer	16/50 (32 %)	18/52 (36 %)
Cause of death unknown	2/50 (4 %)	0 (0 %)

*Matched for: 1) invasive cancer, 2) size of cancer, and 3) involvement of nodes.

Management of Breast Cancer—Crile

such a study if there were a demonstrable difference in survival in the various groups.

Conclusion

The ten-year survival rate of patients who were treated at the Cleveland Clinic by operations less than radical mastectomy is the same as that reported in the National Cancer Registry in similarly staged patients who were treated by radical mastectomy, and the same as that of similarly treated patients reported by Bernard Fisher and his associates of the National Surgical Adjuvant Breast Project.

The situation is best summarized by saying that when there are great differences in rates of survival, these can usually be explained by noting the differences in selection. When the standard radical operation is abolished, I believe women with breast cancer will come earlier for treatment and their chances of survival will be improved.

REFERENCES

1. Haagensen CD: The choice of treatment for operable carcinoma of the breast. *Surgery* 76:685-714, 1974.
2. Cope O, Wang C, Chu A, et al: Limited surgical excision as the basis of a comprehensive therapy for cancer of the breast. *Am J Surg* 131:400-407, 1976.
3. Forrest APM, Roberts M, Preece P, et al: The Cardiff St. Mary's Trial. *Br J Surg* 61:766-769, 1974.
4. Kaas S, Johansen H: Simple vs radical mastectomy for primary breast cancer, in Forrest APM, Kunkler PB (ed): *Prognostic Factors in Breast Cancer*, Livingstone, Edinburgh and London, 1968.
5. Brinkley D, Haybittle JL: Treatment of stage II carcinoma of the female breast. *Lancet* 2:1086-1087, 1971.
6. Burn I: Early breast cancer: The Hammersmith Trial. *Br J Surg* 61:762-765, 1974.
7. Hamilton T, Langlands A, Prescott R: South East Region of Scotland Trial. *Br J Surg* 61:758-761, 1974.
8. Murray JG: Cancer research campaign study. *Br J Surg* 61:772-774, 1974.
9. Wise L, Mason AY, Ackerman LV: Local excision and irradiation: an alternative method for treatment of early mammary cancer. *Ann Surg* 174:392-401, 1971.
10. Sampson RJ, Woolner LB, Bahn RD, et al: Occult thyroid carcinoma in Olmsted County, Minnesota: prevalence at autopsy compared with that in Hiroshima and Nagasaki, Japan. *Cancer* 34:2072-2076, 1974.
11. Hayward J: Conservative surgery in the treatment of early breast cancer. *Br J Surg* 61:770-771, 1974.
12. Crile G Jr: Results of conservative treatment of breast cancer at 10 and 15 years. *Ann Surg* 181:26-30, 1975.
13. Anglem TJ, Leber RE: Characteristics of 10 year survivors after radical mastectomy for cancer of the breast. *Am J Surg* 121:363-367, 1971.
14. US Dept of Health, Education and Welfare, Public Health Service, National Institutes of Health, End Results in Cancer: Report No 4, Washington, US-DHEW, 1972.
15. Fisher B, Slack N, Katrych D, et al: Ten year follow-up results of patients with cancer breast in a co-operating clinical trial evaluating surgical adjuvant chemotherapy. *Surg Gynecol & Obstet* 140:528-534, 1975.
16. Sandison AT: Autopsy study of the adult human breast. *Nat Cancer Instit Monog* No 8, Bethesda, Maryland, 1961.
17. Rich AR: On the frequency of occurrence of occult carcinoma of the prostate. *J Urol* 33:215-223, 1935.
18. Campson RJ, Key CR, Bucher CR, et al: Thyroid carcinoma in Hiroshima and Nagasaki. *J Am Med Assoc* 209:65-70, 1969.
19. Robbins GF, Berg SW: Bilateral primary breast cancers. A prospective clinicopathological study. *Cancer* 17:1501-1527, 1964.
20. Slack N, Nemoto T, Fisher B: Experiences with bilateral primary carcinoma of the breast. *Surg Gynecol & Obstet* 136:433-440, 1973.
21. Peters V: Cutting the Gordian knot in early breast cancer. *Ann R Coll Phys Surg Can* 7:186-192, 1975.

Tenuate®
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Tenuate Dospan®
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Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma, agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychological dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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Special Reports

MEDICAL ROUNDS AT A TROPICAL DISEASE HOSPITAL

I made my third annual field trip for the VA to American Samoa on June 2 through June 7, 1978. Samoa is 2700 miles south of Honolulu and is about a five-hour flight by Pan American. This lovely tropical island in the South Pacific is an American protectorate. It is about eight by 33 miles and has a population of 33,000 people. The only medical facility on the island is the L.B.J. Tropical Disease Center, which is run by the Department of the Interior.

The hospital consists of five identical-size, one-story frame structures connected by one hallway. The buildings have wooden shingles, and the sides are largely screen. Samoa receives about 200 inches of rain each year, (as in Somerset Maugham's *Rain*) so a good roof is important.

The hospital has 180 beds, usually averaging about 100-120 beds occupied; the week I was there only 55 beds were occupied. Most of the paramedical staff is from Samoa; many of them trained at nearby Suva in Fiji. Most of the physicians come for two-year rotations from the United States as do some of the nurses. Some physicians come for one- or two- or six-month rotations.

Dr. Antonelle is a new internist here from New York City and only a few years out of her residency. Her husband obtained a job here flying for one of the local airlines. The morning we made rounds, we saw twelve medical patients, all located in rooms containing three beds. All patients in the hospital were Samoans.

The first patient was seen in ICU, a 27-year-old woman with known rheumatic heart disease, whose aortic valve had been replaced with a porcine valve at Queen's Medical Center in Honolulu in 1977. She had come in the night

before in heart failure with tachycardia and hypotension and was being stabilized in ICU. When stable, she will be reevaluated in Honolulu at Tripler Army Medical Center.

The second patient was a 70-year-old woman with right lower quadrant mass following an appendectomy in February of 1978. The next was a 77-year-old elderly female with diabetes, dehydration, and a blood sugar of 500. Diabetes and gout are both common in Polynesians. We next saw a 70-year-old male with hematuria and prostatism, and he was transferred to Tripler Army Medical Center for a TUR. In the next bed was a 55-year-old male with fever of unknown origin with a history of malaria in 1951 and 1960.

The 60-year-old gentleman in the next bed had a fascinating combination of diagnoses. For many years he had been carried as "ulcerative colitis." He was treated for amebiasis in 1976. When his diarrhea was worked up on this admission, *Giardia* was identified—that is an unusual parasite in Samoa. The treatment was to be Atabrine.

The next four patients all had leprosy. The



Dr. Vandervort and Dr. Antonelle



Rainmaker Mountain, Pago Pago, American Samoa

first was a 40-year-old male who also had asthma. He had previously been treated for hookworm. He is now under treatment with Hetrazan for *Microfilariae*. He had a number of fingers missing. A 24-year-old male was in the next bed. On his back were noted circular skin

lesions that were biopsy positive for leprosy. He had been started on treatment in 1974 but had stopped treatment and had now relapsed. Thickening of the ulnar nerves was evident. Across the hall was a 23-year-old male who had had leprosy since 1976. There were several cases in his family. He had missing fingers and mutilated hands with a 3 cm trophic ulcer on the lateral left ankle and absence of sensation in both feet. Next to him was a 50-year-old male with far-advanced leprosy with mid-radial bilateral amputations, absent toes, and trophic ulcers on his feet. He is blind in the left eye and has only partial sight in his right eye.

There are said to be 300 cases of leprosy on the island. New cases are as follows: 1972—14; 1973—10; 1974—21; 1975—20; and 1976—28. The young are most susceptible; the old seem more resistant. It is said that one gets leprosy by living with lepers. The doctors and nurses in the hospital who care for these people do not get leprosy. The local health officer states that

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STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

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A. Total Number Copies Printed	1315	1315
B. Paid Circulation		
1. Sales through dealers and carriers, street vendors and counter sales	78	86
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C. Total Paid Circulation	1064	1077
D. Free distribution by mail, carriers or other means		
Samples, complimentary, and other free copies	129	121
E. Total Distribution	1193	1198
F. Copies Not Distributed		
1. Office use, left-over, unaccounted, spoiled after print- ing	122	117
G. Total	1315	1315

I certify that the statements made by me above are correct and complete.

ANNE SHANE BADER

40% of the children of lepers develop the disease, but only 5% of the spouses do so.

The next patient was a 22-year-old, retarded female with rheumatic heart disease. She has had SBE on two occasions. She now has a cystic lesion behind the left eye with absent vision in that eye, plus an inflammatory lesion of unknown cause in the right eye now under treatment with steroids. The diagnosis in the second eye is said to be toxoplasmosis.

We then visited the surgical ward for four consultations; three were obese males in their 60's, all diabetics, with trophic ulcers on their feet. Two of the three were noted to be smoking. We then saw a female diabetic with a trophic ulcer, who was expected to undergo a below-the-knee amputation.

I next visited the Preventive Medicine Section of the hospital. The three most common parasitic infections in Samoa are *Ascaris*, *Trichuris*, and hookworm. Together Dr. Antonelle and I visited a patient with elephantiasis involving the left arm and the right leg. The health officer states that there are 300 patients in Samoa with filariasis. New cases were as follows: 1972—46; 1973—33; 1974—26; 1975—5; 1976—0. A public health team from the Tropical Disease Center screened large segments of the population for filariasis on a routine basis. On a recent screen of 1,000 Samoans, fewer than 1% were positive; the public health officials feel filariasis can be eliminated.

After rounds, we visited other parts of the hospital, and then I bade Dr. Antonelle goodbye. I promised to assist her in transporting and ar-



LBJ Tropical Disease Hospital, American Samoa

ranging for admitting some of the above patients to the Tripler Army Medical Center in Honolulu.

I then returned to the Rainmaker Hotel and reflected on the patients I had just seen. I contrasted them with the patients seen while making rounds at the Delaware, the Memorial, the General, and St. Francis. There were certainly many differences, but there were similarities also. Certainly, the doctors in Samoa had been no more successful with obesity, cigarette smoking, or compliance with medication. On the other hand, progress was evident in dealing with infectious diseases and parasites.

The equipment in the hospitals varies, but the most important is still the physician with his stethoscope, his curiosity, talking over the patient with his colleague, always asking too many questions of the pathologist and the radiologist.

WILLIAM J. VANDERVORT, M.D.



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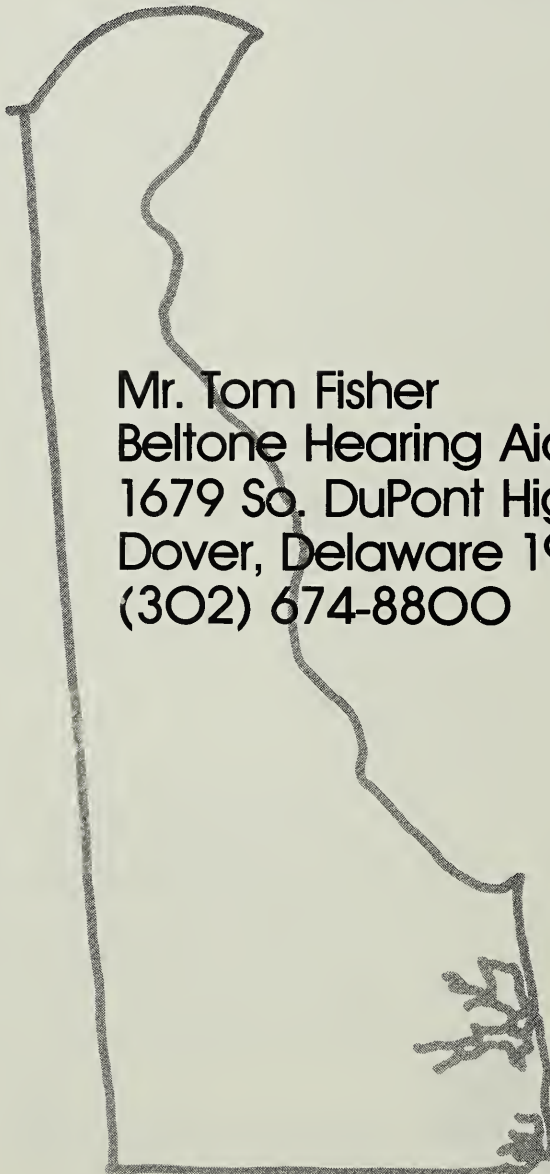
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COMMON SUGGESTIONS ARISING FROM SURVEYS—PART II

LEIF C. BECK, LL.B., CPBC
VASILIOS J. KALOGREDIS, J.D.

In our last article we discussed several areas of concern commonly arising from our surveys of medical practices. This article continues in that vein by considering several other ideas repeatedly arising in surveys we have recently performed.

PROFESSIONAL CORPORATION MATTERS

While we believe professional corporations are excellent formats for many (though not all) medical practices, our surveys have uncovered some common areas of both present and potential future trouble. A few are discussed below.

Taking Full Advantage of the Corporate Form

Many practices are simply not taking full advantage of the professional corporation form. Since incorporation is costly in terms of advisors' fees and other expenditures, we consider such failures to be very unfortunate.

Some doctors, for example, have refrained from committing themselves to a maximum 25 percent retirement plan contribution out of concern that such an annual obligation could be restrictive on their personal finances in future years. The simple solution to such a concern is for the practice to adopt a pension plan (involving a fixed obligation which must be met every year) of approximately 10 percent of compensation and a profit-sharing plan allowing up to 15 percent of salary to be contributed. The advantage of this combination is that since a profit-sharing plan is not obligatory (does not require any annual contribution level), a practice can decide each year to contribute anywhere from 0 percent to 15 percent of all participants' pay into it.

Many physicians have been unaware that their retirement plans allow them to make "voluntary contributions." The voluntary contribution is a worthwhile investment medium for physicians with extra cash to invest. Although it is not tax deductible when made by a doctor from his personal funds, the income generated from it is tax-free (really tax-deferred) until distributed at retirement or other termination of employment with the corporation. The formula for calculation of the maximum amount that can be contributed voluntarily is complex. One should check with his advisors to determine what this figure is for each doctor each year.

Too many physicians have failed to take full advantage of the corporate form and to adopt fringe benefits other than retirement plans. A corporate plan should, for example, generally be established to have the corporation reimburse or pay directly the medical expenses (including medical insurance and disability insurance) of each incorporated physician and other key employees. We strongly recommend that at least one non-physician owner-employee be included in the plan to help counteract potential IRS arguments that it is for "shareholders only" and not for "employees," as tax law requires. We also believe that maximum limits should usually be set as to the amount of benefits the plan will provide (either "dollar-wise" or as a percentage of salary) to make the plan "real."

Group term life insurance is another corporate fringe benefit unknown to many physicians. It allows the corporation to pay for an employee's life insurance with dollars which are tax deductible by the corporation and yet not taxed to the employee. It is thus an excellent vehicle for

Messrs. Beck and Kalogredis are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd, Pennsylvania.

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a physician to add to his present life insurance or replace other more expensive life insurance. Even though a group term program requires that all full-time employees must have some insurance provided for them, in almost every instance group term life insurance will be a very reasonable way to obtain life insurance.

We recently encouraged several survey clients to better "sell" their fringe benefit programs to their staff. The Pension Reform Act requires various notices about fringe benefits, but such information is desirable anyway. Many medical employees are not aware of their benefits; this is unfortunate since a practice should derive whatever employee goodwill such benefits deserve.

Corporate Rescue Jobs

Often we are called in to "rescue" a corporate practice that has not closely followed proper professional corporation protocol. Many of them have "empty minute books," arising from at-

torneys who incorporated the practice and then were not seen or heard from thereafter. Regular and periodic supervision and review by a practice's advisor are, however, necessary to assure that a professional corporation is well run from a practical and a tax point of view.

Many of the details are admittedly more a matter of "form" than "substance," but the IRS has required them in cases challenging professional corporations. Documentation (minute books, employment agreements, stock restriction agreements, and the like) is more important, which is why we believe ongoing attorney involvement is so valuable to corporate success.

For example, we recently surveyed an office where there was no written stock "buy/sell" agreement. The physicians involved could have encountered a disastrous legal problem if one of them had died under those circumstances. They had verbally agreed to a nominal sum as the fair purchase price of the stock at any doctor's death, with salary continuation reflecting the practice's receivables augmenting that sum. The doctors unfortunately did not fully appreciate that without setting the nominal stock price in writing they were leaving themselves open to a potential lawsuit by an executor of a deceased fellow stockholder arguing that the stock value was much greater. (Mr. Beck has testified as an expert witness in just such a case, so such lawsuits can and do arise.) From a technical point of view, they could be forced to pay this higher price unless they were protected by a written document saying otherwise. Therefore, such details should not be ignored.

DOCTORS' MEETINGS

A common complaint of physicians in a group is that "we can never make decisions and follow them through." This is often caused by their failure to sit down as a group to discuss on a regularly scheduled basis the practice's purely business matters.

It is imperative that a group (even two doctors) meet on a regular and programmed basis at least once a month—for example, the third Wednesday of every month at lunchtime. Such times should be inviolate, being marked in all

... in functional G.I. disorders*

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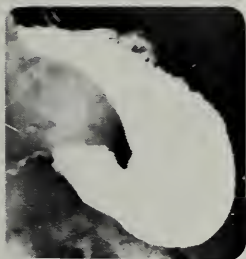
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. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating certain functional G.I. disorders.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary INDICATIONS

For use as adjunctive therapy in the treatment of peptic ulcer. IT SHOULD BE NOTED AT THIS POINT IN TIME THAT THERE IS A LACK OF CONCURRENCE AS TO THE VALUE OF ANTICHOLINERGICS/ANTISPASMODICS IN THE TREATMENT OF GASTRIC ULCER. IT HAS NOT BEEN SHOWN CONCLUSIVELY WHETHER ANTICHOLINERGIC/ANTISPASMODIC DRUGS AID IN THE HEALING OF A PEPTIC ULCER, DECREASE THE RATE OF RECURRENCES, OR PREVENT COMPLICATION.

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders); and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon).

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy), obstructive disease of the gastrointestinal tract (as in achalasia, pyloro-duodenal stenosis), paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: autonomic neuropathy; hepatic or renal disease; ulcerative colitis—Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon; hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension; hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis). Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: Adults: 1 or 2 capsules or teaspoonfuls syrup three or four times daily. Children: 1 capsule or teaspoonful syrup three or four times daily. Infants: ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: Adults: 1 tablet three or four times daily. Bentyl Injection: Adults: 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. **MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of October, 1976

the doctors' schedules well beforehand so that nothing else is scheduled during that period.

If the particular practice has an office manager or other "key aide," we normally recommend that she also be involved in such meetings. The "manager" is often the one who will have to implement the authorized actions or at least see that they are implemented, and we believe most arguments for complete confidentiality even from a key aide are mistaken. The meetings also afford the doctors and the manager an opportunity to discuss any office problems in a way that the manager can communicate to the staff as to matters relevant to them. This approach has worked particularly well in some practices we recently visited where the doctors previously had never seemed able to get business matters accomplished. By now involving their respective "senior aides" in the management of the practice, things have been running more smoothly and, most importantly, goals are apparently being attained.

We strongly recommend that all physicians have a monthly financial statement prepared within a few days after the end of each month. Often it is prepared by the "key aide," the preparation and reporting being another reason for having that person's attendance at the doctors' meeting. Such a financial statement should be prepared and in the hands of each doctor a few days ahead of the monthly meeting. This timing provides each doctor an opportunity to review the statement prior to the meeting, give it some thought, and have the opportunity to question and/or comment on any items appearing on the statement. The statement thus affords the doctors an opportunity to evaluate the practice's progress and make decisions based upon the realities of the practice's financial situation. Too many practices lack such statements on a regular and timely basis and therefore are often making decisions in a vacuum, without the information needed to make an informed decision.

USE OF ADVISORS

Often related to the question of doctors' meetings and decision-making is the use a practice makes of its advisors—attorneys, accountants, consultants, or whatever.

Doctors often complain that their advisors are

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not advising but merely performing mechanical tasks (such as preparation of financial statements and document drafting) with nothing else. When this complaint arises, we often find that the advisors have never been asked to supply more than that. In some of those instances, once the practice demanded more time from its advisors, more was achieved. In other cases, the advisors could not supply more and were replaced. Either way, the practices benefited.

The need for advisory involvement is especially relevant in professional corporation situations. As described above, some attorneys who incorporate a practice may not be involved after the initial documentation is complete. In our view, however, during the first year of corporate existence a practice's doctors and advisors should meet from three to six times to assure that things are running their proper course; after that first year there should be a least two meetings a year (at mid-year and during the 12th month of the corporate year for year-end planning) with the practice's advisors.

We strongly recommend that corporate meetings be held with both the attorney and the ac-

countant present. In instances in which a doctor meets separately with his accountant and his attorney little or nothing tends to be accomplished since the two advisors may disagree on a matter but lack the opportunity to work out their differences face to face for the doctor's benefit. The doctor can be caught in the middle, having thereafter to telephone each advisor to describe the differences and attempt to come to a decision. It is much better that all advisors meet with the doctor at the same time to allow open discussion and decision for the best interest of the practice.

We also believe such advisors' meetings are important for unincorporated practices. Even an unincorporated practice has various general management, accounting, tax, and other concerns that should be discussed by a doctor or group with its advisors at least a couple of times a year. For example, personnel matters, insurance purchases, fees, collection systems, and the like can and should be discussed with one's advisors who hopefully have experience with other practices that can provide valuable input. The range of client experiences is, of course, the real value of a good advisor.

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Editorials

THE BEST MANAGEMENT OF BREAST CANCER

George Crile, Jr. clarified his position on the primary treatment of breast cancer in his article on "Limited Mastectomy for the Management of Breast Cancer." For at least ten years he has stood firmly against the Halstead radical mastectomy; his concept that this method has no place in the modern primary treatment of breast cancer is gradually being accepted by the surgeons of America. Dr. Crile also clarifies his position on lumpectomy with the statement he has *never* used this method for the treatment of breast cancer.

Central to his article is the conclusion that the abolishment of the standard radical for cancer treatment will overcome the fear on the part of American women of the loss of one or both breasts, a fear which he considers a significant factor in the delay of diagnosis and treatment.

Dr. Crile's reference to the fact that there are great differences in the rate of survival with different surgical approaches, which can usually be explained by knowing the differences in selection, raises the usual criticism of historical studies compared to controlled randomized clinical trials. Certainly the women of America have expressed in a number of ways their desire to be provided with a lesser form of treatment than radical mastectomy. They have also been vocal about their right to informed consent. The surgeon's dilemma is characterized by the fact that as yet no one, including Bernard Fisher, knows the best primary treatment for this disease.

A protocol is now available to compare partial mastectomy with total mastectomy and axillary dissection. This nationwide evaluation, which is being supported by the National Institute of Health, has been designed to compare the cure rate and cosmetic results of three types of surgical treatment for primary operable breast cancer, ie, tumors 5 cm in diameter or less which are not fixed to the underlying chest wall or to the overlying skin. It must be noted that there is as yet no conclusive evidence relative to the

effectiveness of the three treatments under study. The three treatments are: 1) segmental mastectomy—removal of only that portion of the breast which contains and surrounds the tumor, 2) segmental mastectomy followed by radiation therapy to the entire breast, and 3) surgical removal of the entire breast which is classified as total or simple mastectomy. In each of these treatments axillary dissection will be carried out, and to those patients in whom nodes are involved, regardless which of the three surgical treatments was given, chemotherapy using L-Pam and 5-FU is administered in an attempt to control metastasis. The randomization involved in the present study can be provided at the time of biopsy or after biopsy has been done if a two-stage procedure is elected. This protocol was designed after evaluating the results of a previous National Surgical Adjuvant Breast Program protocol which compared standard radical mastectomy with total or simple mastectomy with or without the addition of radiation therapy. Based on that information, there is no difference within the three groups in the pattern of incidence of recurrent disease.

To date, recruitment of patients for this protocol in Delaware has been rather slow; on a national basis it is moving with a little greater speed. It is now important for physicians and surgeons of Delaware to cooperate in this important protocol to help resolve by a scientific method the dilemma of the best primary surgical treatment of breast cancer.

LESLIE W. WHITNEY, M.D.

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CONTINUING MEDICAL EDUCATION: WHO PROFITS?

Recently my secretary kept track of the offerings for continuing education made to me by mail for a period of five weeks. The courses ranged in price from \$50 (a one-day meeting

on nutrition in Kansas City) to a \$3200 three-week trip to visit "the healing centers of Europe and the Middle East." The course I most wanted to take was the second most expensive: a series of seminars and visits to hospitals interspersed with cruising the Nile to visit the Valley of the Kings and other Egyptian antiquities.

During the five weeks, I received 25 offers to be educated. The list of course topics was as broad as the locations. I have no idea what mailing lists were used to circularize me except for the Jefferson-mounted seminar at Rehoboth Beach, an announcement of which must have gone to all members of the Medical Society of Delaware. The intensity of the race for physicians' continuing medical education dollars (which doctors have been ordered to spend by the requirements of their local and national medical societies in preparation for or to forestall the time when the government will do so) has become disgraceful. I would rather not know how often the course material presented truly fills a need for the physicians attending the

meetings, even when the meeting has been chosen by them because of its putative content rather than its location.

Dr. Patrick Storey has more thoroughly and skillfully lamented commercialization of an aspect of medical life which has always been instinctive for most physicians. "What began as a relatively small stimulus, to be applied only to volunteers, is now a shock to be endured by all,"¹ he says. CME is an example of a new business which shouldn't be.

B.Z.P.

REFERENCE

1. Storey P: Mandatory continuing medical education, one step forward—two steps back. *NEJM* 298:1416-1418, 1978.

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MANNERS IN THE NATIONAL HEALTH ARENA*

Recently I had the wonderful opportunity of attending a week-long seminar on the British National Health Service (NHS) in London. The conference, sponsored by the American Medical

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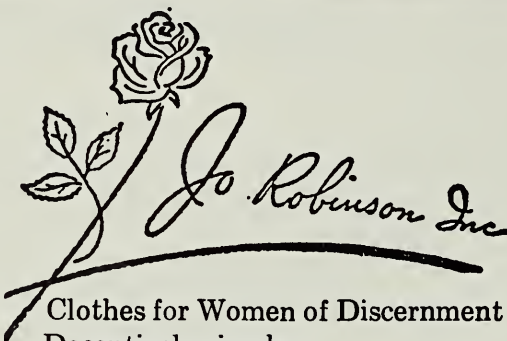
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Association, was attended by about three dozen US physicians, most of them leaders of state and national medical societies, plus a dozen or so medical society executives.

The program provided me with several unexpected realizations. First, it's natural that health planners (or health plan resisters) should be interested in learning as much as they can about the things that have clearly gone wrong, as well as those that might have been done better, in Great Britain in the 30 years since NHS was enacted. Given the present US administration's avowed interest in national health insurance, the experience of the NHS is certain to be even more closely scrutinized than it has been.

It would be foolish for us to assume that because our language is pretty much the same as Great Britain's, we can easily imitate the good points and avoid the bad points of their health care system. One of the strongest reasons we cannot do so is the enormous discrepancy in size and in population density between the two

countries. Great Britain's population of 25 million is about 12 percent of ours, which now stands near the 210 million mark. Great Britain—England, Scotland, Wales, and part of Ireland—is about the size of Oregon, or less than 3 percent the size of the United States. Not only is Britain much more densely populated, but its "rural" population is largely concentrated in villages and small towns, in which the house call remains a practical tool for the family doctor—he can easily make two or three house calls in an hour.

Long before the seminar was over, it was clear to me that aside from fiscal reasons, physicians accustomed to giving primary care in the US could never be professionally content as primary physicians in Great Britain. True, the British general practitioner is a very important part of his patients' lives. But despite his excellent training, he spends his medical life largely as a triage officer. His access to things that we daily take for granted, such as diagnostic X-rays and laboratory tests, has always been limited by custom. Now his access to them is further constrained by regulation.

One fact about the British NHS can and should have great relevance to US planning: To the British government's dismay, the cost of the NHS hugely exceeded the most imaginative estimates. Inflation explains part of that, but a bigger reason is that the medical and ancillary social human needs of the British citizenry have been found to be essentially infinite. So would ours.

A seemingly trivial incident that depressed me occurred at dinner at the House of Commons. After cocktails on a great stone terrace overlooking the Thames, we sat down at one long table. Including spouses, we must have numbered close to 80 people. The china was German, not English (Yes, I turned my bread and butter plate to peek). The waitresses wore white gloves, but the napkins were paper. They were embossed with "House of Commons," so perhaps it was not for austerities but to provide a souvenir of what should have been a totally pleasant evening.

Toward the end of dinner, our host, a member of the House of Commons, rose and proposed a toast to Her Majesty, the Queen. "One doesn't

smoke at table in England before the Queen is toasted," whispered my companion on the left, an expatriate British anesthetist who explained that he still keeps two passports so he can use the one he feels will be most hospitably received by each country he visits. We all raised our glasses and sipped to the Queen's health.

Our host then followed with, "And now a toast to your President, Mr. Carter." Knowing that this group was not likely to include many who had voted for Mr. Carter, I glanced around to see the facial expressions of my toasting colleagues. To my incredulity, all the wine glasses within my vision remained poised somewhere south of their holders' lips. I heard a brief half-laugh, half-grunt. Then, leaving the President of the United States untoasted, this group of visiting US physicians and their associates in medical administration sat down to continue a social hour at table.

Anarchy? At the time I thought so. Maybe that's too strong, but it was certainly unconscion-

able rudeness. This little episode seems to me a worrisome portent for the coming months and years, during which a US variety of national health insurance will be formulated.

It should now be clear that the financing of US medical care will continue to become more federalized irrespective of who is President. It is important to all physicians that physicians' judgment be included in the crucial developmental processes. Good manners must become an ingrained attitude of the upcoming discussions if physicians are to help define the inevitable increasing regulation of our professional lives and our pocketbooks. At least in public business, the US Congress meticulously adheres to a policy of exquisite politeness between political opponents.

If US physicians in toto have manners as bad as those displayed by the group at the House of Commons dinner party, our privilege of being part of the planning may be rapidly forfeited.

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Book Reviews

BASIC PSYCHIATRY FOR THE PRIMARY CARE PHYSICIAN edited by Harry S. Abram, M.D., Little, Brown and Company, Boston, 1976. 291 pp. Price \$12.50. Paperback.

This is an interesting and informative compendium of the emotional aspects of common problems faced by the primary care physician. It is not a psychiatric textbook though there is a chapter on outpatient-type disturbed patients—the ambulatory schizophrenic, the depressed, the hysterical, and the paranoid patient. Another goes into depth distinguishing between delirium and dementia. The introduction, somewhat long and tedious, gives four different versions of doctors with respect to their appreciation of and cooperation with psychiatrists and vice versa. The subsequent chapters, each written by one or two authors, are quite worthwhile though some stand out above the others. I was particularly impressed by one on the adolescent patient and another by two Harvard professors on the myocardial infarction patient. There are a good review of drug abuse and alcoholism and an up-to-date listing and description of psychotropic drugs. Sleep disorders, sexual problems, the dying patient are some of the other headings that provide both fresh information and comprehensive views. The final is a multiple choice Q&A on each chapter, seemingly a *sine qua non* these days. I would recommend this text to any doctor interested in the patient, not just the disease.

WILLIAM D. SHELLENBERGER, M.D.

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RADIOLOGIC PHYSICS, EQUIPMENT AND QUALITY CONTROL by William R. Hendee, M.D., Edward L. Chaney, M.D., and Raymond E. Rossi, M.D., Year Book Medical Publishers, Chicago, 1977. 289 pp. Illus. Price \$18.75.

Today, there is an ever-increasing amount of new radiological equipment, requiring a better understanding of how it works. This interesting and informative book takes a close look at the

mechanics of radiology. The subjects covered are expanded beyond those normally found in an introductory text on radiology.

This book is divided into three parts. The first part covers x-ray production, radiation safety, and radiobiology; the second part discusses the characteristics of radiologic equipment and how to achieve the best results when using the equipment; and the third part examines image quality and the need for quality control during clinical use of the equipment.

While physicians in any field might read this book, I feel that its strongest application is for radiologists and others closely involved with radiologic practice.

JOSEPH R. PEACOCK, M.D.

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DISEASES OF THE NOSE, THROAT AND EAR, 12th ed., by John Jacob Ballenger, M.S., M.D., Lea & Febiger, Philadelphia, 1977. 1118 pp. Illus. Price \$60.00.

A standard text of diseases of the ear, nose, and throat should be included in all physicians' libraries, even if only as a source of general reference. This text admirably fills the need. The many contributors have done an outstanding job.

The major headings are: The Nose and Accessory Sinuses, The Pharynx and Fauces, Diseases of the Larynx, and The Ear and Bronchoesophagology. Each section details the clinical anatomy of the area in question and proceeds through its various diseases and their treatments. The chapters are in general quite detailed in the presentation of the particular subject under discussion, with appropriate anatomical drawings to illustrate the region under discussion.

A fairly large percent of the book is devoted to surgical problems and procedures. Of particular interest is the section of the book dealing with the complications of ear disease and the management of these problems.

While the text is well-edited, well-presented, and designed, there is one minor thing which would tend to, I feel, enhance its value. With all the pathology presented certainly something more than line or pen and ink sketches could have been used as illustrations. The same comment can be applied to any disease state and to many of the surgical procedures discussed.

This text is certainly sufficient in all its aspects. It will probably appeal more to the specialist than to the general practitioner or internist, but it can be freely recommended to both as an outstanding reference text.

ETHAN G. FLAKS, M.D.

PHYSICAL PERFORMANCE, FITNESS AND DIET by D. R. Young, B.S., M.A., Ph.D., Charles C. Thomas, Publishers, Springfield, Illinois, 1977. 113 pp. Price \$9.75.

This monograph is solidly packed with state-

ments by many authors for which many references are appended to each chapter. Unless one is already deeply versed in this historical review, there is often considerable difficulty in following the discussion. Most of the investigation reported is on humans, but under very stressful conditions such as starvation, obesity, high fat diet, high carbohydrate diet, etc. Physical performance is measured largely by the treadmill. Just what is meant by fitness is not clearly stated. Nevertheless, the main thrust and importance of the large consumption of any one of the major food substances are well stated. The discussion of growth hormone and glucose in the presence of insulin is interesting, but the equations and terminology to describe the investigating model are in a language, I suppose, known only to a few scientists.

The author spends some time interestingly, explaining that the Masai in Africa eat only meat, blood, and fermented milk, yet have low serum cholesterol, no coronary disease, and are physi-

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cally very fit. He does not, however, mention that a neighboring tribe, who are just as active physically and who follow the same diet, have high serum cholesterol and do have a lot of coronary disease. It has been suggested elsewhere that the reason may be ethnic: in the genes of the Masai there seems to be a biochemical feedback which keeps the synthesis of cholesterol at a low level.

The chapter entitled Sports Medicine seems out of place. The theme is that sports activities aid in physical performance and well-being, but less so than a job which requires physical activity. The main emphasis here seems to be on the orthopedic accidents which may occur during active sports. This chapter could have been eliminated.

The monograph otherwise is small, compact, filled with references, and should be useful to anyone conducting research in this area. It has no great appeal for physicians unless they are also biochemists. After all, the author is not an M.D.

LEWIS B. FLINN, M.D.

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THE ADULT POSTOPERATIVE CHEST by Myron Melamed, M.D., Florencio A. Hipona, M.D., Carlos J. Reynes, M.D., Walter L. Barker, M.D., and Santiago Parades, M.D., Charles C. Thomas, Publisher, Springfield, Illinois, 1977. 578 pp. Illus. Price \$31.50.

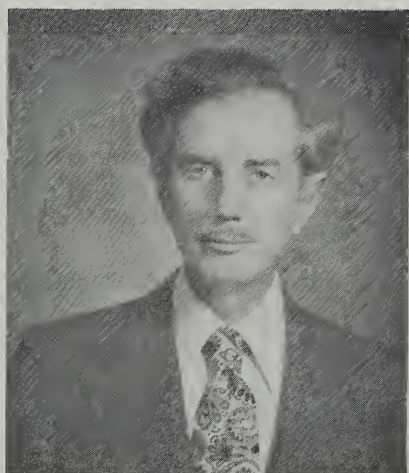
The purpose of this book as I understand it is to consider the effects of surgery on the technique and interpretation of the postoperative chest x-ray. To this end a great number of x-rays and a small amount of text are provided. The x-rays are superb, but I found the text to frequently treat the subject in a superficial manner and not to add appreciably to the comments presented with each x-ray.

The first chapter is on General Surgical Considerations, and the above comments fit this perfectly. It could just as well have been incorporated into the subsequent chapters. In addition, there are brief discussions of technical considerations and postoperative care, both of which might have been omitted.

The heart of the material is contained in two chapters, one on "Air-Fluid in the Pleural Space" and the other titled "Complications." These two chapters occupy over half of the space in this

book. Both show numerous examples of well reproduced x-rays with good interpretations. Some of the x-rays are museum pieces; these include prombage thoracoplasty with lucite balls

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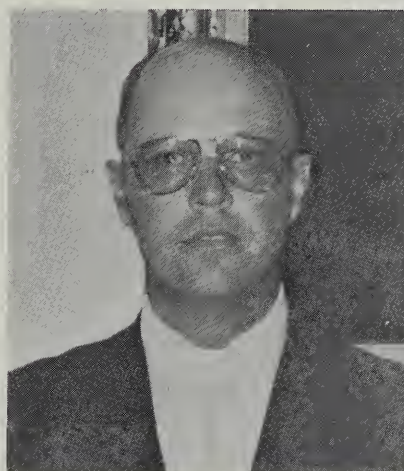
CALVIN B. HEARNE, M.D.

Doctor Hearne is the recipient of the 1978 Medical Society of Delaware Distinguished Service Award. The award was presented to Doctor Hearne "in recognition and appreciation of his tireless and devoted leadership and his service to his peers and to the citizens of Delaware."



MARVIN H. DORPH, M.D.

Doctor Dorph is the recipient of the 1978 President's Award on the basis of his devotion to Medical Society affairs.



JAN DeLONG

A citation was presented to Mr. Jan DeLong, Executive Director of the Delaware Health Council, "in recognition and appreciation of his outstanding contributions in planning for the future needs of the citizens of our state and as an expression of our respect and affection for him as a distinguished Delaware citizen." (Editor's Note: Mr. DeLong died on October 21 while this issue was in press.)

Book Reviews

and with paraffin. I have not seen films of these in years. One minor criticism is that indications are not stated for the procedure that is portrayed on the x-ray. This would be helpful but does not detract from the films themselves.

There are other chapters on Radiologic Evaluation of the Postoperative Heart, on Congenital Cardiovascular Lesions in the Adult, and Acquired Cardiovascular Disease. The chapter on Pulmonary Function after Surgery does not belong in this book.

In summary, this is an excellent compendium of x-rays. They are clearly explained and represent the gamut of films seen in the postoperative period. The text is superficial and fragmentary, but this is not a major drawback. This book can be recommended to anyone interested in chest disease, to surgeons or pulmonary specialists, to roentgenologists, and to all those who see patients after chest surgery.

LEONARD P. LANG, M.D.

CLINICAL SIMULATIONS: SELECTED PROBLEMS IN PATIENT MANAGEMENT by Christine H. McGuire, Lawrence M. Solomon, and Philip M. Forman, Appleton-Century-Crofts, New York, 1976. 424 pp. Illus. Price \$23.50.

It is in the nature of a programmed simulation text such as this to give Evelyn Wood graduates a nervous breakdown. It cannot be read, it must be thought through. This volume, originating as an attempt at meaningful evaluation of the clinical skills of students at the University of Illinois Medical School, is now presented to a more general audience.

The book consists of twenty problems—medical, surgical, obstetric-gynecologic, and pediatric—which begin with a simple statement of the patient's complaints. The reader may then opt for further history, physical exam, laboratory exam, or treatment. Information is revealed by the Access® system of developing invisible ink with a special marker. At appropriate points in the evaluation one is referred to x-rays, EKG's,

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and color plates in a section at the end of the book. To add to the realism, one is liable to be told after an inappropriate measure that the patient has taken a sudden turn for the worse; but with any luck, and some skill in maneuvering the maze of programming, one is asked for a final diagnosis and referred to an appendix for discussion. A recommended flow sheet is provided and appropriateness of each choice is evaluated.

Some of the problems were maddeningly simple, while others reminded me of my inadequacy with patients and problems which I have not seen in some time. On the other hand, I did not agree in every instance with the judgment of the authors, and I expect that might be the case with any reader of a book of this nature. I enjoyed working through the cases and found them on the whole interesting and on occasion instructional. The frustration when the program did not lead to the result expected was in every way a simulation of real life.

JON WESTON, M.D.



THE JOYS AND SORROWS OF PARENTHOOD formulated by the **Committee on Public Education, Group for the Advancement of Psychiatry**, Charles Scribner's Sons, New York, 1973. 159 pp. Price \$5.95.

This book was formulated by the Committee on Public Education of the Group for the Advancement of Psychiatry, which has a membership of about 300 distinguished psychiatrists, most of whom are organized in the form of working committees directing their efforts towards the study of various aspects of psychiatry.

This text of approximately 130 pages was "prepared with the public in mind," hoping that "it will be a useful reference for high school and college courses in family living."

This unique book concerns itself with parents' expectations for themselves, instead of the more usual discussion of parents' expectations for their children. The inside jacket cover states that the book will answer questions parents constantly ask themselves such as, "What have I learned?", "How have I grown?", "What joys and pleasures am I experiencing in addition to enduring parenthood?"

The general impression I got from reading it

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is that there are more sorrows to being a parent than joys. I recommend it to people considering having children as well as to those with children who need to develop the positive mental mechanisms to cope.

THOMAS E. DYER, M.D.



ESSENTIALS OF THE NEUROLOGICAL EXAMINATION by **Bernard J. Alpers, M.D., Elliott L. Marshall, M.D.**, F. A. Davis Company Publishers, Philadelphia, 1977. 175 pp. Illus. Price \$6.50. Paperback.

The new sixth edition of this brief and clearly written monograph still provides the student and practitioner with a good reference for the neurologic exam. It does introduce a general approach to the neurologic patient, but it is less lucid and complete than other textbooks for this purpose. This well-indexed paperback seems most useful as a refresher reference that can rapidly supply needed and often "atrophied" information about the neurologic exam and can aid the physician in attempting to document a neurologic problem. The section on laboratory tests is brief by design and does little more than define some of the

Book Reviews

techniques used in neurologic investigation. Its price is attractive enough to win a place on the office shelf.

S. CHARLES BEAN, M.D.

AMBULATORY PEDIATRICS II edited by Morris Green, M.D. and Robert J. Haggerty, M.D., W. B. Saunders Company, Philadelphia, 1977. 500 pp. Illus. Price \$21.00.

Ambulatory Pediatrics gives an overview of common office problems as seen in the US. It covers some pediatric emergencies and very few surgical conditions. The book emphasizes the promotion of well child care, preventive pediatrics, anticipatory guidance, developmental evaluations, psychologic disorders, and aspects of pediatric psychiatry.

Students, house officers, and nurse clinicians should find this book useful as an orientation for many situations which do not necessarily require a diagnostic workup or specific prescription (medication). It is not likely to replace a standard (1800 page) textbook of pediatrics, but does complement basic textbooks in terms of parenting, health promotion, and psychosomatic

and psychologic disorders. It probably will not be a "best seller" in third world countries, as there is no emphasis on tropical diseases, malnutrition, or vitamin deficiencies.

1977 YEAR BOOK OF PEDIATRICS edited by Sydney S. Gellis, M.D., Year Book Medical Publishers, Chicago, 1977. 420 pp. Illus. Price \$19.95.

1978 YEAR BOOK OF PEDIATRICS edited by Sydney S. Gellis, M.D., Year Book Medical Publishers, Chicago, 1978. 394 pp. Illus. Price \$21.95.

Both Year Books start with a current literature quiz, giving the clinician an opportunity for self-assessment. The 19 chapters are organized by broad topics such as The Newborn, Ophthalmology, Blood, and Child Development. Each journal article is briefly summarized. It is almost always followed by an editorial comment which critiques the article, often with a jaundiced eye, constructive criticism, or a humorous line to give a reasonable perspective about the topic.

These books can serve as a quick reference review for the busy clinician who wishes to update his knowledge of pediatrics.

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In Brief

Speakers on "Ask the Doctor"

Speakers for November on the Tuesday radio program (11:05 a.m., WDEL), produced by the Medical Society of Delaware are: November 7, *Pierre L. LeRoy, M.D.*, What's New in Pain; November 14, *Thomas M. Mannis, M.D.*, Hypothyroidism; November 21, *Joshua Kalin, M.D.*, Dyslexia; November 28, *George R. Hilty, III, M.D.*, Immunizations.

Explorer Post No. 530

Physicians participating in November in the Exploring Program for Explorer Post No. 530, sponsored by the Medical Society of Delaware, are: November 1, *Ben C. Corballis, M.D.*; November 15, *John E. Hocutt, Jr., M.D.*

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Doctor of the Year Award

David Platt, M.D., was one of eight finalists for the 1978 Family Doctor of the Year Award, sponsored by *Good Housekeeping* Magazine in cooperation with the American Academy of Family Physicians. He was nominated by the Delaware Academy of Family Physicians. According to the Executive Editor of *Good Housekeeping*, "the choice was extremely difficult, owing to the uniformly high caliber of the finalist group from which the selection was made . . . Our admiration (to you) for the high standards of family medicine practice that you represent." An article on the award is in the October issue of *Good Housekeeping*. The Family Doctor of the Year Award was presented to Dr. Mario E. Ramirez of Rio Grande City, Texas.

In the News

Dr. Vidya Sagar, Wilmington, has been appointed by Governor duPont to the Council on Radiation to fill an unexpired term until November 16, 1979.

CLINICAL NOTICES AND MEETINGS

Cardiovascular Diseases

A joint meeting of the FIRST INTERNATIONAL CONGRESS ON CARDIOVASCULAR DISEASES and the 14th ANNUAL SCIENTIFIC ASSEMBLY of the American Society of Contemporary Medicine and Surgery will be held January 14-19, Caesar's Palace, Las Vegas, Nevada. Participants may receive up to 40 hours of CME credit in Category I. For information contact: Rutledge W. Howard, M.D., CME Director, American Society of Contemporary Medicine and Surgery, 6 North Michigan Avenue, Chicago, Illinois 60602.

Sports Medicine

The Dartmouth-Hitchcock Medical Center will present WINTER SPORTS' MEDICINE, January 17-19, Woodstock Inn, Woodstock, Vermont. There is a \$150 registration fee which includes tuition and social activities. For information contact: Office of Continuing Medical Education, Dartmouth-Hitchcock Medical Center, Hanover, New Hampshire 03755.

In Brief

Radiology Course

The University of Texas Medical School at Houston, Department of Radiology, and the University of Texas Health Science Center at Houston, School of Allied Health Sciences and Division of Continuing Education will present **RADIOLOGY OF THE ACUTELY ILL AND INJURED PATIENT—UPDATE 1979**, January 26-27, Stouffer's Hotel, Greenway Plaza, Houston, Texas. The program meets the criteria for 14 credit hours in Category I of the Physician's Recognition Award of the AMA. Application has been made to the American College of Emergency Physicians for 14 ACEP Category I credits and to the American Academy of Family Physicians for 14 Prescribed credit hours. For information contact: Division of Continuing Education, The University of Texas Health Science Center at Houston, P.O. Box 20367, Houston, Texas 77025. Telephone: (713) 792-4671.

Neurological Update

The Department of Neurology, University of Miami School of Medicine, will sponsor the **SIXTH ANNUAL NEUROLOGICAL UPDATE SYMPOSIUM**, January 29-February 2, Konover Hotel, Miami Beach, Florida. For information contact: Division of Continuing Medical Education D23-3, University of Miami School of Medicine, P.O. Box 016960, Miami, Florida 33101. Telephone: (305) 547-6716.

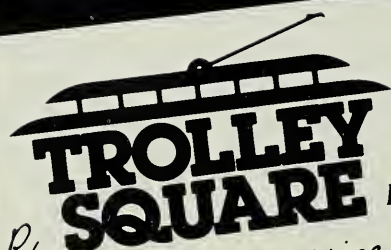
Biomedical Symposium

The 1979 **SAN DIEGO BIOMEDICAL SYMPOSIUM** will be held February 7-9, San Diego, California. The Symposium, sponsored by the San Diego Biomedical Society, has focused its attention on interdisciplinary topics in medical, biological, and engineering technologies. For information contact: San Diego Biomedical Society, Inc., P.O. Box 80543, San Diego, California 92138.

Beth Israel Hospital Programs

The following programs are sponsored by the Beth Israel Hospital, Denver, Colorado. All of the meetings have been approved for AMA Category I credit. For information,

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direct the inquiry to the particular meeting, P.O. Box 11366, Denver, Colorado 80211.

FOURTH ANNUAL VAIL FAMILY PRACTICE CONFERENCE, February 10-17, The Mark, Vail, Colorado.

SECOND ANNUAL VAIL UROLOGY CONFERENCE, February 10-17, Lion Square Lodge, Vail, Colorado.

FIFTH ANNUAL VAIL OB/GYN CONFERENCE, February 17-24, The Mark, Vail, Colorado.

FOURTH ANNUAL VAIL PSYCHIATRY CONFERENCE, February 17-24, Lion Square Lodge, Vail, Colorado.

FIRST ANNUAL VAIL EMERGENCY MEDICINE/CRITICAL CARE CONFERENCE, February 17-24, Kiandra-Talisman Lodge, Vail, Colorado.

NINTH ANNUAL ASPEN RADIOLOGY CONFERENCE, February 24-March 3, Aspen Institute for Humanistic Studies, Aspen, Colorado.

SECOND ANNUAL VAIL CANCER CONFERENCE, March 3-10, Kiandra-Talisman Lodge, Vail, Colorado.

FOURTH ANNUAL VAIL GENERAL SURGERY CONFERENCE, March 10-17, The Mark, Vail, Colorado.

FIRST ANNUAL VAIL GERONTOLOGY CONFERENCE, March 10-17, Lion Square Lodge, Vail, Colorado.

FOURTH ANNUAL VAIL INTERNAL MEDICINE CONFERENCE, March 17-24, The Mark, Vail, Colorado.

FIRST ANNUAL VAIL PEDIATRICS CONFERENCE, March 17-24, Lion Square Lodge, Vail, Colorado.

Symposium on Cancer Research

The University of Texas System Cancer Center will present the 32nd Annual Symposium on Fundamental Cancer Research, RADIATION BIOLOGY IN CANCER RESEARCH, February 27-March 2, Shamrock Hilton Hotel, Houston, Texas. For information contact: Stephen C. Stuyck, M.D. Anderson Hospital and Tumor Institute, Houston, Texas 77030. Telephone: (713) 792-3030.

Occupational Lung Disease Conference

The American College of Chest Physicians will host the INTERNATIONAL CONFERENCE ON OCCUPATIONAL LUNG DISEASE, February 27-March 2, San Francisco, California. For information contact: Mr. Dale Braddy, Director of Education, American College of Chest Physicians, 911 Busse Highway, Park Ridge, Illinois 60068.

ACP Courses

The following programs, approved by the American Medical Association for Category I credits toward the Physician's Recognition Award, are sponsored by the American College of Physicians. For information contact: Registrar, ACP, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

FLUID AND ELECTROLYTE BALANCE, HYPERTENSION AND RENAL DISEASES, December 4-8, Northwestern University Medical School and Northwestern Memorial Hospital, Chicago, Illinois.

RECENT ADVANCES IN GASTROENTEROLOGY, January 11-13, University of Arkansas, Little Rock, Arkansas

PRESENT CONCEPTS IN INTERNAL MEDICINE, January 22-26, Letterman Army Medical Center, Letterman Army Institute of Research, Presidio of San Francisco, California.

FIFTH STANFORD-PALO ALTO MEDICAL RESEARCH FOUNDATION WINTER COURSE IN INFECTIOUS DISEASES, January 29-February 2, Stanford University School of Medicine and Palo Alto Medical Research Foundation, Keystone, Colorado.

INTENSIVE CARE MEDICINE, February 5-9, St. Vincent's Hospital and Medical Center of New York, New York.

HEMATOLOGY—FROM THE LABORATORY TO THE BEDSIDE, February 12-14, Lake Tahoe, Nevada.

NEPHROLOGY—CURRENT THEORY AND PRACTICE, February 14-16, Royal Victoria Hospital Board and McGill University, Montreal, Mount Gabriel, PQ, Canada.

VIRGINIA REGIONAL MEETING, February 17, Omni International Hotel, Norfolk, Virginia.

AHA Stroke Conference

The American Heart Association will present the 4th **JOINT CONFERENCE ON STROKE AND CEREBRAL CIRCULATION**, February 8-10, Hyatt Regency Hotel, Phoenix, Arizona. For information contact: Administrator, Postgraduate Programs, American Heart Association, 7320 Greenville Avenue, Dallas, Texas 75231.

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cancer communiqué

FROM THE DELAWARE CANCER NETWORK*

INFORMED CONSENT

BARBARA LETANG, M.S.W.

A conference on Informed Consent was held at the Brandywine Hilton, September 27, 28, 1978, sponsored by the University of Delaware College of Nursing and supported by a grant from the Delaware Humanities Forum. The conference was well attended by over 200 nurses and other health care professionals, lay people and educators from academic settings.

It was not well attended by physicians. Yet, it is important for their continuing education that they keep abreast not only of current informed consent laws but also of the attitudes surrounding informed consent and health care issues. There are significant implications for their practice, and this is particularly true for those physicians involved in the care of those with difficult chronic diseases such as cancer. Although informed consent is a legal question in the strictest sense, both speakers and participants were concerned with far broader issues than suing or being sued. This conference provided a forum to discuss relationships among physicians, patients and other health care professionals.

The speakers were outstanding and included nationally recognized authorities such as Robert Veatch, Ph.D., Senior Associate of the Hastings Center Institute; Alexander Capron, Professor of Law at the University of Pennsylvania; Leah Curtin, R.N., M.S., M.A., Acting Director of the National Center for Nursing Ethics and H. Tristram Englehardt, Jr., M.D., Ph.D., Kennedy Center for Bioethics. Reactor panels included qualified and interested local people such as Dr. Martin Gibbs, Chairman of the Medico-Legal Affairs Committee of the Medical Society of Delaware

and his counterpart from the Delaware Bar Association, Walter Pepperman, II, Esq. The Delaware Cancer Network is strongly supportive of this kind of important discussion of issues and roles which affect the day-to-day care of cancer patients and sent Barbara Letang, M.S.W., Supportive Services Coordinator, to act as one of the panel moderators.

The formal presentations accurately described the tensions growing out of increased patient participation and individual choice in treatment decisions and the increased regulatory measures and bureaucracy. Throughout the day, lay people and health care professionals shared an awareness that the current state of informed consent laws have brought mixed blessings to both populations. It was significant to note that in a setting such as this conference it was widely accepted for people to see themselves as both patients and "consumers." The behavioral expectations of those who see themselves as consumers differ considerably from those who see themselves in the traditional doctor-patient relationship. Physicians should be aware that their patients today will have increasingly different expectations of what is to be provided by their physician.

This shift in attitudes, reflected by our informed consent laws, deserves further discussion. It means that physicians have gained important benefits and increased responsibilities in delivering care. Physicians now deal increasingly with well-informed patients capable of active participation in difficult treatment choices such as those involved in the care of cancer. That benefit relieves the physician of making treatment choices

Ms. Letang is Supportive Services Coordinator for the Delaware Cancer Network.

*An NCI-supported agency located at 1200 Jefferson Street, Wilmington, Delaware 19801. Tel. (302) 428-2113.

Cancer Communique

in which personal values must play a heavy role in the decision-making process. The physician must now accept a heavy educational burden, however. Health care has become a complicated web of technology requiring highly specialized training. Physicians must share their learning so that patients can be informed and can make responsible choices. This sharing can be a complex and time-consuming process. It does not have to be carried alone by the physician. There are a number of health care professionals (nurses, social workers, dietitians, pharmacists) ready to assume the rights and responsibilities that go along with educating the patient. If physicians are to practice efficiently, they must learn to involve these other disciplines in the educational process.

It was a provocative conference which stimulated a useful exchange of attitudes, ideas, and expectations among the diverse participants. For those physicians who were unable to attend, perhaps the most important message to be delivered was that there is an increasingly consumer-oriented patient population wanting to be informed, educated, and involved in their own health care choices and that everyone attending recognized both the benefits and burdens from this shifting role.

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WARNINGS **Drug Dependence** Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of PERCOCET[®]-5, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, PERCOCET[®]-5 is subject to the Federal Controlled Substances Act.

Usage in ambulatory patients Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using PERCOCET[®]-5 should be cautioned accordingly.

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Usage in children PERCOCET[®]-5 should not be administered to children.

PRECAUTIONS **Head injury and increased intracranial pressure** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions The administration of PERCOCET[®]-5 or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special risk patients PERCOCET[®]-5 should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

ADVERSE REACTIONS The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include euphoria, dysphoria, constipation, skin rash and pruritus.

DOSAGE AND ADMINISTRATION Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. PERCOCET[®]-5 is given orally. The usual adult dose is one tablet every 6 hours as needed for pain.

DRUG INTERACTIONS The CNS depressant effects of PERCOCET[®]-5 may be additive with that of other CNS depressants. See WARNINGS. 6085 BS

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President's Page

SUPPORT YOUR LOCAL PSRO?

The original concept of Professional Standards Review Organizations (PSRO) was to establish a federally financed plan of medical audit and utilization review, unique in that the audit and review would be performed by physicians and the PSRO regulated and run by physicians. However, because it was a federally mandated program and financed by the federal government, it was immediately subject to suspicion by our profession and by hospital boards and administrators.

Hospital utilization review is certainly not a new concept, and federally mandated utilization review of Medicare and Medicaid patients has been in existence since the mid-1960's. Although this review was federally mandated, the physicians performed this review as unpaid volunteers and performed it quite successfully. Federal programs gradually changed, and salaried reviewers began to take over the utilization review initially done by physician volunteers, with physicians acting as advisors. Physicians steadily lost day-to-day contact with utilization review as paid advisors began to do more of the daily utilization review.

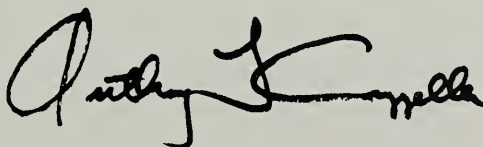
On June 1, 1976, the Delaware Review Organization (DELRO) was designated as a "conditional" PSRO for the entire state of Delaware. Review implementation began in the first Delaware hospital under DELRO on February 1, 1977 and the last hospital on December 1, 1977. At the present time Beebe, Nanticoke Memorial, Riverside, and St. Francis Hospitals are delegated for performance of utilization review and medical audits. Kent General Hospital is delegated for performance of utilization review and medical audit with DELRO providing staff assistance for the audits. The Wilmington Medical Center is delegated for performance of medical audit, and DELRO performs the utilization review. DELRO performs medical audit and utilization review at Milford Memorial, but Milford employs the reviewer.

DELRO and the hospitals collect specific demographic and clinical information on Medicare and Medicaid patients. Through the use of a sophisticated computer hook-up at Yale University DELRO is able to analyze information

regarding patient care and utilization practices in the hospitals.

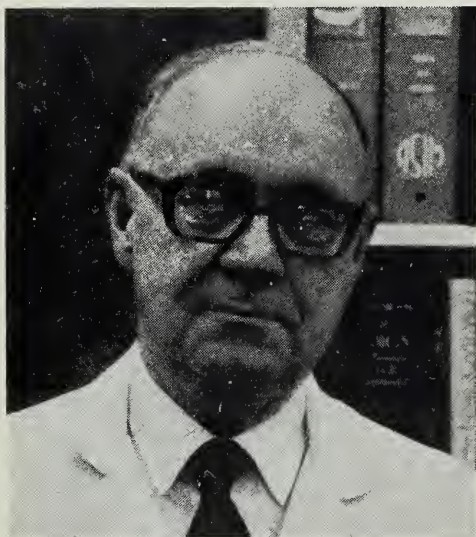
Why then should we support DELRO? The lead article in an economic magazine widely read by physicians devoted itself to the question of PSRO support, and the speaker for the November 1978 meeting of the New Castle County Medical Society addressed the same topic. We live in a data-rich environment, and the future of private medicine may largely depend on the interpretation of that data. The Health Systems Agency in Delaware is in the process of writing a health plan for the State and will need to depend on data to make the proper decisions. Wherefrom that data comes and who interprets it will many times determine whether a good and proper decision is made. For example, data accumulation may show that Medicare patients have a longer length of stay in New Castle County than in corresponding parts of the country, but the data may be so interpreted as to give valid reasons as to why that is so, based on the nature of the illnesses, economic factors, lack of skilled nursing beds, etc. DELRO as an independent, local organization, physician-controlled and operated, has the ability to accumulate and interpret that data in such a manner as is applicable locally and use it to help improve the quality and delivery of health care in Delaware.

The concept of PSRO and the establishment of DELRO represent an organized attempt by government to allow the health industry to regulate itself and do its own professional review. There are undoubtedly many in the department of HEW who would like to see PSRO in its present conception fail or simply just go away. If it does fail, however, something will replace it, and it is almost certain that that something will not be locally or physician controlled. DELRO has a chance to offer a meaningful contribution to the care and quality of care to the patients of Delaware, and it needs our continuing support and guidance.



"THE PHYSICIAN IS A DECISION MAKER, AND ALMOST EVERY DECISION HE MAKES COSTS OR SAVES MONEY."

—Dr. William Felts, Past President,
American Society of Internal Medicine



More and more physicians today are beginning to realize the extent of the economic influence they have, and are finding ways of holding costs down.

A number of studies show that the more physicians *know* about costs, the more they try to *reduce* them*. And this reduction can be done without reducing the quality of care to the patient.

How are they doing this? As a start they have become thoroughly familiar with the costs they incur on behalf of their patients. They know how much an X-ray costs, how much their hospital charges for routine lab tests. They're requesting copies of patients' hospital bills. And asking their hospitals to print the charges for diagnostic tests right on the order sheet.

What else are physicians doing? Minimizing their patients' hospital stays, whenever possible. Reevaluating routine admissions procedures. Questioning the real need of the diagnostic tests they order for their patients. Avoiding duplicate testing. Trying to discourage their patients' demands for unnecessary medication, treatment or hospitalization. Compiling daily logs of their medical decisions and what they cost. And more.

More physicians today realize what a tough problem we're all faced with. They know this is a challenge for medicine. And that physicians are in the best position to deal with and solve the problem.

*PATIENT CARE Magazine—Outlook 1977, "Face-Off: Cost Containment vs. Chaos," January 1, 1977.

Lyle CB, et al. "Practice habits in a group of eight internists," ANNALS OF INTERNAL MEDICINE 84 (May 1976), 594-601.

Schroeder SA, et al. "Use of laboratory tests and pharmaceuticals: variation among physicians and effect of cost audit on subsequent use," JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 225 (Aug. 20, 1973), 969-73.



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COMPARISON OF DIAZEPAM AND SODIUM METHOHEXITAL IN ELECTIVE DC CARDIOVERSION

JOSE G. TIONGSON, JR., M.D.

JANET HELMUTH, R.N.

MARVA AUSTIN, R.N.

CHARLES LINDE, C.R.N.A.

Introduction

Both diazepam (Valium, *Roche*) and sodium methohexital (Brevital, *Lilly*) have been employed as anesthetic agents in elective DC cardioversion, which has been used for the management of certain cardiac arrhythmias since its introduction by Lown et al in 1962.¹ We have not been able to find a report comparing the two drugs.

Diazepam, a synthetic compound belonging to the benzodiazepine class, is often prescribed for the symptomatic relief of tension and anxiety states. It is used intravenously prior to cardioversion for the relief of anxiety and to diminish the patient's recall of the procedure.²

Sodium methohexital is a rapid, ultra-short-acting barbiturate anesthetic agent useful for induction of anesthesia or as an agent for inducing a hypnotic state.³ It offers distinct clinical advantages in that it leads to a very rapid anesthetic induction, has no cumulative effect, and is very rapidly metabolized, leading to a shorter recovery period.

All the apparent disadvantages ascribed to the use of the short-acting barbiturates in general actually were predominantly seen with the use of sodium thiopental. When used to modify electroconvulsive therapy, thiopental has been noted to be associated with more frequent

electrocardiographic abnormalities, a prolonged period of apnea, and an increased incidence of laryngospasm.^{4,5}

In a comparison study of thiopental and methohexital in the induction of anesthesia in electroconvulsive therapy, investigators at Washington University School of Medicine confirmed that methohexital causes a rapid and complete anesthetic induction, usually with no need for premedication, and is associated with significantly fewer electrocardiographic abnormalities. In addition, virtually no cases of laryngospasm were seen.

The purpose of our study was to compare prospectively the use of IV Valium and IV Brevital as an anesthetic in elective DC cardioversion for cardiac arrhythmias. In this paper we relate our experience with these drugs when used randomly for patients who underwent cardioversion between June 1976 and August 1977.

Materials and Methods

This study evaluated elective cardioversion procedures performed between June 1976 and August 1977 at the Veterans Administration Center in Wilmington, Delaware. All procedures were carried out in the Medical Intensive Care Unit (MICU). Personnel involved included the medical supervisor of the intensive care unit, a MICU nurse, and a nurse anesthetist. To limit subjective observation bias, only two nurses were asked to participate in the study. With the exception of two procedures, only one nurse anesthetist was involved during the study.

Dr. Tiongson is Medical Supervisor, Medical Intensive Care Unit, and Staff Member, Department of Medicine, Veterans Administration Center, Wilmington, Delaware.

Ms. Helmuth is Head Nurse, Medical Intensive Care Unit, Veterans Administration Center, Wilmington, Delaware.

Ms. Austin is Staff Nurse, Medical Intensive Care Unit, Veterans Administration Center, Wilmington, Delaware.

Mr. Linde is a Certified Registered Nurse Anesthetist.

TABLE 1 — SUMMARY OF CLINICAL OBSERVATIONS

Patient No.	Age	Sex	Diagnosis	Dose of Drug	Induction Time	Duration of Hypnosis	Analgesia	Significant Hypotension	Respiratory Depression	Energy Used	Result Counter
VALIUM											
4	56	M	RHD, Atrial Flutter-Fib.	10 mg.	2 min.	6 min.	Unaware No Pain	None	Respiratory rate dropped from 16 to 8 immed. after shock	75 joules	NSR
6	53	M	ASHD, Atrial Flutter	15 mg.	3 min.	3 min.	Unaware No Pain	None	None	25 joules	NSR
8	61	F	ASHD, Atrial Flutter	7.5 mg.	2 min.	7 min.	Pt. aphasic No Pain	None	None	25 joules	NSR
9	82	M	ASHD, Atrial Fibrillation	9 mg.	4 min.	2 hours & 23 min.	Unaware No Pain	None	15 second apnea after inj. of drug	100 joules	NSR
12	55	M	ASHD, Atrial Flutter-Fib.	20 mg.	2½ min.	3 min.	Aware No Pain	None	None	25 joules	NSR
BREVITAL											
1	55	M	RHD, Atrial Flutter-Fib.	100 mg.	2 min.	8 min.	Aware No Pain	None	None	50 j. 75 j.	Atrial NSR
2	57	M	RHD, Atrial Fib.	100 mg.	1 min.	15 min.	Unaware No Pain	None	None	100 j. 150 j. 175 j. 200 j.	Atrial Atrial Atrial NSR
3	46	M	ASHD, Atrial Flutter	75 mg.	6 min.	5 min.	Unaware No Pain	None	Respiratory rate dropped from 20 to 12/min. immed. after shock	50 joules	NSR
5	58	M	ASHD, Atrial Fibrillation	70 mg.	4 min.	6 min.	Unaware No Pain	None	None	100 j. 150 j.	Atrial NSR
7	66	M	ASHD, Atrial Flutter	75 mg.	3 min.	12 min.	Unaware No Pain	None	None	50 joules	NSR
10	47	M	ASHD, Atrial Flutter	65 mg.	1 min.	3 min.	Unaware No Pain	None	None	50 joules	NSR
11	65	M	ASHD, Atrial Fibrillation	70 mg.	3 min.	14 min.	Aware No Pain	None	10 second apnea after shock	50 j. 75 j.	Atrial NSR

The patients were randomly assigned to receive either Valium or Brevital. Only the nurse anesthetist knew which drug was being administered to each patient. All the necessary observations were made and recorded by the MICU nurse involved.

A total of twelve procedures were performed in nine patients, three patients being cardioverted on two separate dates. Four of the nine patients had multiple shocks during each procedure. The patients ranged from 46 to 82 years of age. Eight were male. The indication for the procedure was either atrial flutter or atrial fibrillation.

Digitalis was withheld from every patient for at least 24 hours prior to the procedure. All patients received 300-400 mg of quinidine sulfate one to three hours prior to cardioversion. Each patient received some form of oxygen therapy prior to and during the procedure.

Methohexital (Brevital) was administered intravenously in a 1% solution at a rate of 1 cc per 5 seconds until hypnosis was induced.

Valium was administered intravenously undiluted with an initial dose of 5 to 10 mg in one minute. If no response was noted after ten minutes, additional incremental doses of up to 5 mg at a time were given IV every ten minutes thereafter.

One to four shocks were given as necessary. The energy setting varied from 25 to 200 watt-seconds (joules).

Results

Our observations are summarized in Table 1. Induction time was defined by us as the time from the injection of the drug to the time the nurse anesthetist gave the go signal for the countershock. Duration of hypnosis was determined from the time the nurse anesthetist gave the go signal to the earliest time the patient fully recovered consciousness and was able to answer appropriately questions of orientation to time, person, and place. To evaluate the analgesic effect, patients were asked two questions when fully recovered: whether they were aware of the procedure. Three patients stated that countershock, and whether they experienced mild, moderate, severe pain, or no pain at all.

Induction of hypnosis occurred within one to six minutes. No patients experienced pain during the procedure. Three patients stated that they were aware of the countershock, but all three of them stated that they did not have any pain. No significant fall in blood pressure was noted. Only two short episodes of apnea were noted. One was of 15 seconds' duration after Valium injection; the other, ten seconds in duration, occurred after the countershock was given. In the latter patient, Brevital was the drug used.

The total dose of Valium utilized varied between 7.5 and 20 mg and that of Brevital, between 65 and 100 mg. The duration of hypnosis for patients who received Brevital varied between three and 15 minutes; it was between three minutes and two hours and 23 minutes in those who received Valium. The patient who slept for two hours and 23 minutes was an 82-year-old male patient who received 9 mg of Valium. No untoward effects were noted except for a 15-second period of apnea following the injection of the drug. The prolonged hypnotic effect noted in this one patient can probably be explained on the basis of his age and an increased excretion time of the drug.

Cardioversion in every patient was successful.

Summary and Conclusion

Adequate hypnosis and analgesia with no significant cardiovascular or respiratory side effects were achieved by the use of either IV Valium or IV Brevital as an anesthetic agent for elective cardioversion.

When Brevital was compared with Valium, no significant differences were noted by us in terms of efficacy and incidence of side effects. The disadvantages attributed in the past to the barbiturates in general were actually the results of experiences with the use of sodium thiopental.

We conclude that Brevital and Valium are equally effective in achieving rapid and safe anesthetic for DC cardioversion.

REFERENCES

1. Lown B, Amarasingham R, Neuman J, Berkovitz BV: Use of Synchronized Direct-Current Countershock in the Treatment of Cardiac Arrhythmias, read before the 54th Annual Meeting of the American Society for Clinical Investigation, Atlantic City, New Jersey, April 30, 1962.
2. Roche Laboratories insert on Valium (diazepam) April, 1977.
3. Goodman LS, Gilman A: The Pharmacological Basis of Therapeutics, 5th ed, pp 189-192. New York, Macmillan Co, 1975.
4. Pitts FN, Gilles MD, Wendell S, Schaberg AB: Induction of anesthesia with methohexital and thiopental in electroconvulsive therapy. *NEJM* 273:353-359, 1965.
5. Muenster JJ, Rosenberg MS, Carleton RA, Graettinger JS: Comparison between diazepam and sodium thiopental during DC countershock. 199:168-170, 1967.



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TREATMENT OF ANXIETY: PHENOBARBITAL VERSUS THE BENZODIAZEPINES

NEIL H. SHUSTERMAN, M.D.

For a number of years the drug most frequently prescribed by physicians in the United States has been Valium. Last year over 50 million prescriptions were written for this drug alone, and more than twice that number were written for all antianxiety drugs combined.¹

An action repeated often enough becomes a habit about which one ceases to think. Is this the case with the benzodiazepines? Are they prescribed so frequently because it has become a routine act for doctors who scarcely think twice about writing for Valium or Librium, Serax or Tranxene? Valium costs at least ten times as much as phenobarbital. Is the more expensive anxiolytic worth the difference?

To compare completely the benzodiazepines to the barbiturates four factors should be considered: efficacy, safety, compatibility with other drugs, and economy.

Physician and patient attitudes towards medication have been shown to have significant influence on how effective a particular drug is.² As anxiety is often responsive to such measures as reassurance, explanation, and suggestion and often is a temporary situational problem, it can be quite difficult to separate placebo effect from drug effect. In most reported studies, both the barbiturates and the benzodiazepines have been shown to be more effective in relieving the symptoms of anxiety than are placebos, but even placebos work a fair amount of the time.²⁻⁴ As far as efficacy is concerned, all of the benzodiazepines are equal in their ability to relieve anxiety.^{1,5,6}

The major barbiturate used for daytime sedation is phenobarbital, though shorter-acting drugs such as amobarbital or butabarbital have been prescribed. Several studies seem to have shown that the benzodiazepines are more effective than the barbiturates, but one should look closely at these results.^{2,7,8} Many times a global rating scale was used whereby a patient's condition is assessed in terms of excellent, very good, good, fair, or poor. Point values were assigned to these terms and statistical analysis performed. The fallacy is that the rating scales usually were poorly validated. One observer's "excellent" may be another physician's "very good." None of these studies attempted to evaluate reproducibility. Furthermore, who is to say an excellent rating is worth five points while a poor one is worth only one point?

One of the most recent studies has used physician-and-patient-rated anxiety scales to assess change in condition.⁷ Two of these are the Hamilton Anxiety Scale and the Spielberger State-Trait Anxiety Inventory. Here again the difference between the benzodiazepines and phenobarbital has been shown to be "statistically significant" in favor of the benzodiazepines. But this must be critically considered in order to avoid being trapped by the fallacy of equating statistical significance with biological significance. All that statistical evaluation can say is whether a difference between two groups is likely to have occurred by chance alone. It is up to the researcher to convince the reader that the difference is of sufficient meaning to be valuable in clinical practice. In my opinion, the above study fails to provide evidence that the "statistically significant" difference means any-

Dr. Shusterman is a 1978 graduate of Thomas Jefferson University School of Medicine. This paper was prepared while on family practice rotation at the Wilmington Medical Center.

thing to the clinician. That the numbers are "significantly different" does not prove that the patients differ in an appreciable way, for it is difficult to interpret what if anything a point difference on an anxiety scale means at the clinical level.

At the present time there seems to be no hard evidence that the benzodiazepines are clinically more effective than the barbiturates. Both groups are sedative-hypnotics; both probably work by achieving a degree of sedation and disinhibition. Both can impair judgment and performance when given in too high a dose, and both can be titrated to give maximum benefit with minimal side effects. The claim that the benzodiazepines have an antianxiety effect before sedation begins is based more on advertising legend than on clinical facts.³

Whereas relative efficacy between the benzodiazepines and the barbiturates has been shown to be nearly identical, the question of safety has been convincingly answered in a different fashion. The benzodiazepines are safer drugs, and for this reason alone many clinicians feel justified in prescribing them rather than barbiturates.⁹

It is true that on a long-term basis the problems of tolerance, physiologic dependence, and withdrawal reactions exist for both groups, but they are worse for the barbiturates; therefore under the conditions of extended use or poor physician monitoring, benzodiazepines would be preferred.³ On a short-term basis, the barbiturates probably do not cause any more tolerance or dependency than do the benzodiazepines.

In the case of acute overdosage, the barbiturates are more likely to cause serious morbidity and mortality than similar overdose with a benzodiazepine.^{4,5} Thus a patient thought to be a significant suicidal risk should not be given a barbiturate. Also, the possibility of accidental ingestion by others should be considered if the patient has young children at home. In small to moderate quantities for short periods and with adequate warning to a responsible adult, however, the barbiturates can be safely prescribed. Definite contraindications to the barbiturates are pulmonary disease, asthma, drug sensitivity, and porphyria.

In terms of compatibility with other drugs, barbiturates are well known for interactions, most

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significantly with anticonvulsant and anticoagulant drugs.⁵ In patients already receiving these, a benzodiazepine would probably be preferred; however, the benzodiazepines do interact with other drugs, including standard anticonvulsant medications.⁴ In patients who are not receiving anticoagulants or anticonvulsants compatibility is not a factor and barbiturates may be utilized.

The main purpose of this comparative analysis has been to remind physicians to think critically when they prescribe antianxiety agents. Phenobarbital is an effective, economical drug that relieves anxiety rapidly, reliably, and with few side effects. There is no convincing evidence that the benzodiazepines are more effective, even though many pharmaceutical advertisements suggest it. When prescribed thoughtfully and monitored carefully, phenobarbital may frequently be an appropriate drug to use.

A patient population in whom follow-up is questionable and potential abuse a worry, is an example of a group in which great care should be exercised in prescribing any sedative medication but especially barbiturates. Yet, in private practice where patients are well known to the physician, phenobarbital might often be used instead of diazepam.

In general, all of the benzodiazepines are more expensive than any of the barbiturates. This price difference is usually eight- to tenfold for comparably effective dosages.⁵ From the patient's viewpoint, it might be a welcome change to discover that not all prescribed medicines are expensive.

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REFERENCES

1. Blackwell B: Psychotropic drugs in use today: the role of diazepam in Medical Practice. JAMA 225:1637-1641, 1973.
2. Wheatley D: Benzodiazepines and anxiety states. Proceedings of the Royal Society of Medicine. 66:255-256, 1973.
3. Elliott HW, Aagaard GN: Drug therapy of anxiety. Postgraduate Med 54:159-164, 1973.
4. Kiev A: Minor tranquilizers: perceptive management of the anxious patient. Drug Therapy 2:105-116, 1972.
5. Blackwell B: Rational drug use in the management of anxiety. Rational Drug Therapy 9:1-7, 1975.
6. Ricca J: Clorazepate dipotassium in anxiety: a clinical trial with diazepam and placebo controls. J of Clin Pharmacology 12:286-290, 1972.
7. Cohen J, Gomez E, Hoell NL, et al: Diazepam and phenobarbital in the treatment of anxiety: a controlled multicenter study. Current Therapeutic Research 20:184-193, 1976.
8. Rickels K, Clark E, Etezady H, et al: Butabarbital sodium and chlordiazepoxide in anxious neurotic outpatients: a collaborative controlled study. Clinical Pharmacology and Therapeutics 11:538-550, 1970.
9. Meares R: The place of barbiturates in psychiatric treatment. Med J Australia 1:1207-1209, 1970.

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A COMPARISON OF NARCOTIC USAGE BY PATIENTS ADMITTED TO FAMILY PRACTICE AND ONCOLOGY SERVICES

JOHN E. HOCUTT, JR., M.D.

Introduction

Whether the axiom that oncology patients require a significantly greater amount of narcotic pain relief than do other patients actually holds true has been recently debated.

Some oncologists have stated that there may be no significant difference in the total amount of narcotic used by the two patient groups. In order to provide a quantitative answer to this question at the Wilmington Medical Center, a comparison of narcotic usage over a six-month period by oncology and family practice patients was made.

Materials and Methods

All patients included in this study were admitted to either 4-South or 2-South, General Division, Wilmington Medical Center, from January 1 through June 30, 1976, and were given narcotics from the General Division pharmacy during their inpatient stay. Only narcotic usage while in the hospital was included.

Dr. Hocutt is a family practitioner in Wilmington. At the time this paper was written he was a family practice resident at the Wilmington Medical Center.

Patients in the study were categorized either C (cancer, oncology) or NC (non-cancer, non-oncology) by their admitting diagnosis. The admission diagnosis was used because patients in this study whose cancer was diagnosed during their hospital stay were all family practice patients and received most of their medical care from family physicians. Thus narcotic usage for these patients more properly fits into family practice treatment procedures.

When the admitting diagnosis was "rule out cancer" (or a specific type of cancer), the patient was assigned to the NC group. Three patients were discarded from the study because their admitting diagnosis did not allow assignment to either the C or NC groups.

In all instances, the patient's primary diagnosis or principal reason for admission was used for classification and the distinction between C and NC was made by reference to *Clinical Oncology*.¹ All diagnoses recognized in *Clinical Oncology* as cancer (including lymphomas and Hodgkin's disease) were labeled C. Any diagnoses not de-

TABLE 1

DISTRIBUTION OF ADMISSIONS FOR
PHYSICIANS WITH AT LEAST 10 ADMISSIONS

Physician or Group	Total Admissions	4-South	2-South	Non-Cancer Dx	Oncology Dx	% Cancer
A _c	171	2	169	1	170	99.4%
B _c	158	47	111	5	153	96.8%
C	44	44	0	41	3	6.8%
D	34	34	0	30	4	11.8%
E _c	32	9	23	1	31	96.8%
F _c	30	26	4	15	15	50.0%
G _c	28	8	20	0	28	100.0%
H	24	24	0	23	1	4.1%
I	21	21	0	21	0	0%
J	17	16	1	16	1	5.9%
K	13	13	0	13	0	0%
L	11	11	0	11	0	0%
M	10	9	1	9	1	10.0%

scribed in the above reference as cancer or not even mentioned in the book, were classified as NC.

Physicians' services were declared oncology if more than 95% of their patients admitted during the study had a C (oncology) diagnosis. Three physicians and a radiotherapy group were so classified. (They are indicated in Table 1 by a

subscript c [eg, Ac].) Only physicians or physician groups with ten or more admissions during the six-month period were listed. All physicians with less than 90% oncology patients were considered to have family practice services for this study. (Table 1)

Amount of narcotic consumption is expressed

TABLE 2

	Equivalent Dose	Equivalent Dose /10	Equivalent Dose Factor
Morphine	10 mg	1	1.0
Demerol	100 mg	10	0.1
Codeine	120 mg	12	0.083
Methadone	10 mg	1	1.0
Dilaudid	1.5 mg	.15	6.66
Leritine	40 mg	.4	2.5
Levo-Dromoran	2 mg	.2	5.0

A Comparison of Narcotic Usage—Hocutt

in milligrams for meperidine hydrochloride (Demerol), morphine, codeine, methadone, hydromorphone hydrochloride (Dilaudid), anileridine hydrochloride (Leritine), and levorphanol tartrate (Levo-Dromoran). Tablets of oxycodone (Percodan) were omitted from the calculations because it is difficult to convert these tablets to an equivalent dosage form. Percodan was used primarily by the oncology service, so the

trends demonstrated by this study are not affected by omitting Percodan.

Narcotic equivalencies taken from Goodman and Gilman² were calculated for this study as shown in Table 2.

Equivalent doses are approximate and are based on the subcutaneous route.² Nearly all narcotic medications were given by an effective

TABLE 3

FLOOR SUMMARY 2-SOUTH						
Month	Total Admissions	C*	NC**	Males	Females	Average Age
January	71	71	0	48	23	59.8
February	54	54	0	26	28	57.2
March	71	70	1	23	48	57.1
April	64	64	0	20	44	58.2
May	51	51	0	14	37	57.9
June	<u>41</u>	<u>41</u>	<u>0</u>	<u>15</u>	<u>26</u>	<u>60.1</u>
TOTALS	352	351	1	146	206	58.3

=====

FLOOR SUMMARY 4-SOUTH						
Month	Total Admissions	C	NC	Males	Females	Average Ag
January	79	16	63	46	33	56.6
February	55	15	40	20	35	59.3
March	73	10	63	22	51	57.5
April	71	11	60	30	41	58.5
May	60	15	45	29	31	60.4
June	<u>73</u>	<u>31</u>	<u>42</u>	<u>41</u>	<u>32</u>	<u>58.1</u>
TOTALS	411	98	313	188	223	58.3

*C - Patients with an oncology diagnosis

**NC - Patients with a non-oncology diagnosis

TABLE 4

NARCOTICS CONSUMED BY FLOOR - JANUARY -JUNE, 1976

NARCOTIC	2-South Milligrams	4-South Milligrams	Total mgs Consumed	2-South Equivalent Dose	4-South Equivalent Dose	Total Equivalent Dose
Demerol ¹	22,600	18,910	41,510	2,260	1,891	4,151
Morphine	15	140	155	15	140	155
Codeine	6,135	4,965	11,100	511	414	925
Methadone	6,762	2,627.5	9,389.5	6,762	2,628	9,390
Dilaudid ²	2,458	10	2,468	16,370	66	16,436
Leritine ³	1,850	875	2,725	4,625	2,188	6,813
Levo-Dromoran ⁴	77	0	77	<u>385</u>	<u>0</u>	<u>385</u>

Total Equivalent Doses - - - - - 30,928 7,327 38,255

Average Equivalent Dose Per Patient - - - - - 87.8 17.8

Ratio of Equivalent Doses Per Patient - - - - - 4.9 : 1

Equivalent Dose - For explanation, see Methods and Materials Section.

1. meperidine; Demerol, Winthrop.
2. hydromorphone; Dilaudid, Knoll.
3. anileridene; Leritine, Merck Sharp & Dohme
4. levorphanol; Levo-Dromoran, Roche.

or appropriate route (eg, Demerol and morphine were given parenterally, while methadone was given po). Thus, the computed equivalent doses are easily accurate enough for comparison.

The total narcotic equivalent dose was computed by multiplying total mgs of each narcotic listed above by its equivalent dose factor and adding the products. The total equivalent dose per patient was obtained by dividing the total equivalent dose by the number of patients under comparison.

Results

The majority of patients (313 of 411) admitted to 4-South during the six-month period were non-oncology patients. (Table 3) All but one of the 351 patients admitted to 2-South during the six months were oncology patients. Thus, review of the narcotic use comparing the floors

alone would be a comparison of narcotic use for oncology versus family practice patients. This comparison is especially valid because the patient population on the two floors was similar in sex and age distribution. The major difference in the two patient populations was in admitting diagnosis, 2-South being primarily oncology and 4-South predominantly non-oncology.

Table 4 illustrates narcotic use by patients on the two floors. Comparing equivalent narcotic doses per patient reveals a 4.9 times greater narcotic use by 2-South patients than by 4-South patients.

Secondly, narcotic use by services was compared. Tables 5A and 5B compare the total narcotic use by oncology service patients (421 of 422 have C diagnoses) to that of family practice service patients (35 of 341 have C diagnoses, ie, 10.3%). Examining total narcotic equivalent

TABLE 5A
ONCOLOGY SERVICE COMPARED TO FAMILY PRACTICE SERVICE

	2-South	4-South	No. of Patients with Cancer Diagnosis*	% with Cancer Diagnosis
Oncology Service Patients	352	70	421	99+
Family Practice Service Patients	0	341	35	10.3%
Totals	352	411	456	59.9%

*456 of 763 patients had a cancer diagnosis.

doses per patient by services reveals a sixfold greater use by oncology service patients.

Finally, narcotic use by diagnosis is summarized in Table 6. The difference here is most striking. Equivalent dose ratios show a greater than 20-fold (22.6:1) narcotic use by oncology patients than by non-oncology patients.

Discussion

Admission procedures at the Wilmington General Division are directed at maintaining the 4-South floor for the family practice service and the 2-South floor for the oncology staff. Review of admission data indicates that 2-South is all oncology but that a part of the oncology service

TABLE 5B
ONCOLOGY SERVICE (422 PATIENTS) NARCOTIC USAGE COMPARED TO FAMILY PRACTICE SERVICE (341 PTS.)

	2-So. Onc.	4-So. Onc.	Total Onc.	Total F.P.	Total mg. Used	Onc. Svc. Eq. Dose	F.P. Svc. Eq. Dose	Total Eq. Dose
Meperidine	22,600	1,560	24,160	17,350	41,510	2,416	1,735	4,151
Morphine	15	0	15	140	155	15	140	155
Codeine	6,135	2,835	8,970	2,130	11,100	747.5	177.5	925
Methadone	6,762	2,222.5	8,984.5	405	9,389.5	8,985	405	9,390
Dilaudid	2,458	6	2,464	4	2,468	16,410	26	16,436
Leritine	1,850	0	1,850	875	2,725	4,625	2,188	6,813
Levo-Dromoran	77	0	77	0	77	385	0	385
Total Equivalent Doses						33,583.5	4,671.5	38,255
Average Equivalent Dose Per Patient						79.6	13.3	
Ratio of Equivalent Doses Per Patient						6	1	

TABLE 6

NARCOTIC USAGE BY DIAGNOSIS

	C *(mgs)	NC*(mgs)	Total mgs Consumed	Equivalent Dose C	Equivalent Dose NC	Total Equivalent Dose
Meperidine	32,610	8,900	41,510	3,261	890	4,151
Morphine	135	20	155	135	20	155
Codeine	8,880	2,220	11,100	740	185	925
Methadone	9,389.5	0	9,389.5	9,390	0	9,390
Dilaudid	2,468	0	2,468	16,436	0	16,436
Leritine	2,725	0	2,725	6,813	0	6,813
Levo-Dromoran	77	0	77	385	0	385
Total Equivalent Doses				37,160	1,095	38,255
Average Equivalent Dose Per Patient				81.5	3.6	
Ratio of Equivalent Doses Per Patient				22.6	1	

*C - Oncology diagnosis, 449 admissions

**NC - Non-oncology diagnosis, 314 admissions

has spread to 4-South. Despite the spill-over, 4-South is still predominantly family practice. Thus, comparison of narcotic usage on the two floors alone provides a reasonably accurate measure of narcotic use by the two patient groups (C and NC), which are similar in age and sex distribution.

Analyses based upon three variables all indicate that oncology patients at the Wilmington Medical Center are receiving more narcotic pain medications than family practice patients.

Probably the most important variable in narcotic ingestion is the patient's own need or desire for the medication. As virtually all narcotic orders are written as prn, the patient has much direct influence on how much medication he consumes.

Secondly, physician prescribing practices di-

rectly control narcotic use inside the hospital; however, most if not all physicians in this review are not unduly restrictive in writing for prn narcotic medication if the patient or the nursing staff convinces the physician of the need. Thus, the variable of physician effect on narcotic use is probably minimal at the Wilmington Medical Center since the accepted pattern of the prn order enables the patient and the nurse to influence actual medication to a larger degree.

The dispensing habits of prn pain medication by 2-South and 4-South nurses may be different; there was not enough mixture of both services between the two nursing staffs to measure any potential difference. A review of the 70 oncology patients treated by the 4-South nursing staff, however, revealed that the patients received at least twice the narcotic medication per patient as the family practice patients on the same floor.

A Comparison of Narcotic Usage—Hocutt

This fact leaves unresolved the extent to which the two nursing staffs may differ in their influence on narcotic administration. It does suggest that the findings of this study (that oncology patients are receiving more prn narcotic medication than family practice patients) are independent of the two nursing staffs. The fact that the better than two to one ratio (oncology patients' narcotic use to family practice patients' narcotic use) is no greater than it is may be discounted for at least two reasons. The number of patients is small and a concerted effort is made to have the "sickest" oncology patients on the second floor.

Comparing narcotic use per patient by service alone reveals an even greater difference. On the average, an oncology service patient receives six times more narcotics than a patient on the family practice service.

Finally, comparing narcotic ingestion per patient by admitting diagnosis (either cancer or non-cancer) indicates a most remarkable difference. In this review, patients diagnosed as having cancer received on the average more than 22 times the narcotic medication taken by patients without cancer as an admitting diagnosis.

It has been suggested by the radiation therapy section of the oncology department that its patients require less narcotic medication than do medical oncology patients. It is difficult to separate the groups for analysis since the two subspecialties must and do work so closely together. Perhaps further investigation could uncover such a difference.

Summary

Narcotic usage over a six-month period by oncology and family practice patients at the General Division of the Wilmington Medical Center was compared. Oncology patients used significantly more narcotic medication than family practice patients.

ACKNOWLEDGMENT

Mr. Philip W. Tipping helped in the tabulation of these data. This study was supported by a grant from the Department of Family Practice, Wilmington Medical Center.

REFERENCES

1. Clinical Oncology for medical students and physicians; a multidisciplinary approach. University of Rochester School of Medicine and Dentistry, New York, 4th ed, 1974. Published by American Cancer Society.
2. Goodman LS, Gilman A: Pharmacological Basis of Therapeutics, 5th ed, p 248, 1704. New York, MacMillan Company, 1975.

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SHOULD A MEDICAL PRACTICE BUY ITS OWN TELEPHONE?

LEIF C. BECK, LL.B., CPBC
VASILIOS J. KALOGREDIS, J.D.

In the past, almost everyone casually assumed that only the "Bell System" could satisfy one's telephone needs. Up until recently, it was tough to argue against this premise.

The Government has done a lot to strike down "Ma Bell's" virtual monopoly on telephone equipment. For example, in June of this year the Federal Communications Commission ruled that an owner of a private telephone system no longer had to pay the telephone company a monthly charge for a coupling device intended to protect the telephone network nationally from possible harm from private telephone equipment. This resulted in a savings of as much as \$13 per line per month.

This ruling has helped make real cost savings possible to telephone equipment owners. Therefore, sound-thinking physicians should seriously investigate and consider the equipment alternatives to "Ma Bell."

More and more phone users are switching to telephone ownership. Although ownership is not for everyone, doctors owe it to themselves to evaluate its pros and cons objectively.

Generally, the private telephone systems (known as interconnect companies) are much better from a cost standpoint. Each monthly Bell telephone bill contains significant charges simply for the equipment use (for each telephone, button, line, etc.). These "rental" charges typically appear as the first line of the monthly bill's charge summary. A practice can eliminate that line from the monthly phone bill by buying all the telephone hardware from an interconnect company.

The savings can be substantial. We recently

Messrs. Beck and Kalogredis are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd, Pennsylvania.

compared the cost of purchasing against the Bell System's monthly equipment charges. Our total monthly Bell equipment charges were \$265. By borrowing the funds to purchase comparable equipment from an independent telephone supplier, we could pay \$150 a month (assuming a twelve-percent interest, five-year loan from a bank). After that five-year period, the note would be totally paid off, and the entire \$265 per month (which ignores Bell increases which undoubtedly would occur) would be saved—approximately \$3,200 per year. Savings such as this cannot be passed over lightly.

Some have argued that possible telephone equipment obsolescence should discourage buying one's phones. We feel that is generally a weak argument, when compared to the dramatic cost savings usually involved. After all, what benefit (asset-wise) does one get by paying Ma Bell's monthly "rent" bills?

Also, reduced telephone bills are not the only dollar advantage to the purchaser. An owner can depreciate the equipment and take the very valuable ten percent (10%) investment tax credit on it. That can be a real plus for high tax-bracketed physicians.

One must be wary of fly-by-night companies. Be careful in selecting a good one. Many large and reputable firms are in the field. It is important that a physician seek out several interconnect companies in his geographic area. They usually can be found in the Yellow Pages under Telephone Equipment and Systems. One might also seek leads from his management consultant, attorney, or accountant.

Many of these companies have been involved in telecommunications for years and can provide extensive lists of health-care practices using their equipment locally. Others are op-

portunists, mere fledglings into a new growth business in an extremely competitive market where an unsound company can easily and quickly fail. So one must be sure to have the credentials of a prospective supplier closely scrutinized before becoming involved.

A real concern in switching to an interconnect company's system is service. The Bell System must continue full line service and connection to one's privately purchased equipment.

Some feared that "Ma Bell" would not be as cooperative when dealing with offices with privately owned phones. The Government has made it clear that Bell cannot so discriminate. The experience has been that such concerns, which existed somewhat in the past, are generally no longer a problem.

The Bell System does generally have excellent service—both in terms of personnel and parts. That quality is difficult for interconnect companies to match.

In checking an interconnect supplier's references, service is one area to be critically explored and evaluated. If a practice is not located in a large metropolitan area, it can be a very real problem. One should find out where the nearest service center is located and how well it is staffed. For example, many interconnect companies may not be able to guarantee prompt (within two hours) emergency service in Wellsboro, although they could in Philadelphia.

In evaluating a company's service, have its maintenance contract closely reviewed (ideally by one's advisors). Established companies tend to offer a five-year maintenance agreement. The

first year is usually free. The other years are prorated. A system we recently reviewed called for a \$1.75 per unit per month maintenance fee for the second through fifth years.

The problem of a possible breakdown in a private phone system may not be as dramatic as some might think. The telephone company is required to provide one of its phones for every line brought into the office. If the private phone system did happen to break down, one could have the security of some Bell phones to back it up temporarily.

Also, be sure any contract spells out what is promised in writing. For example, if two-hour service is guaranteed for emergencies, be sure "emergencies" are satisfactorily defined.

Physicians should get assurances from the interconnect company that switchover from Bell equipment to owned equipment will not disrupt office hours. If coordinated well the switch should only take a few hours during non-peak telephone periods—perhaps on a weekend.

Physicians should be sure that the system selected is suitable to their needs. A conservative forecast of growth should be anticipated. Ideally, an expandable system should be sought.

One should be wary of overbuying. Remember, a salesman is being dealt with. One should not buy every gadget available just because it is available.

In conclusion, unless a physician is planning to retire in a few years, he should have the question "Should I buy my telephones?" critically evaluated.

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Editorials

PNEUMOCOCCUS VACCINE

Early this year, *Merck, Sharp and Dohme* introduced a vaccine containing the polysaccharides of 14 types of pneumococcus designed to protect adults and children (over the age of two) from various infections due to the pneumococcus. The 14 strains included in the vaccine are responsible for 80% of the pneumococcal infections seen in the United States. (Eighty-three strains of pneumococcus have been identified.)

Release of the vaccine was met by disinterest on the part of physicians and patients alike. This apathy probably stems from the outbreak of Guillain-Barre syndrome which was related to the swine flu vaccine program. Another possibility is that the disinterest in pneumococcal vaccine results from physicians (and patients) failing to recognize the incidence or severity of pneumococcal infections.

Pneumonia is a leading cause of death in this country, and the pneumococcus is the most frequent pathogen in bacterial pneumonia. It is estimated that one-half million Americans have pneumococcal pneumonia each year, and 25% of these are bacteremic. Most important is the fact that 17% of the bacteremic patients die from their pneumococcus infection despite the administration of appropriate antibiotic therapy. In patients over the age of 50 and those with serious underlying disease, the mortality rate approaches 30%.

A significant number of patients experience overwhelming pneumococcal infection with death occurring in the first few days of illness. These infections, frequently cryptic in nature, are characterized by massive bacteremia with accompanying DIC. This phenomenon may be due to the large quantities of circulating polysaccharide.

Patients at risk for overwhelming pneumococcal infection include those who have had splenectomies and those who have diseases characterized by impairment of splenic function (such as sickle cell anemia). Other susceptible patients include those with lipoid nephrosis, cirrhosis of the liver, chronic obstructive pulmonary disease, alcohol-

ism, diabetes mellitus, and diseases of the lymphoproliferative system.

Some authorities suggest that all individuals over the age of 50 should be given this vaccine because of the increased mortality from bacteremic pneumococcal pneumonia in this age group. Although immunosuppressed patients may not show a good response to the pneumococcal vaccine, they should have the advantage of its possible protection.

Since the pneumococcus is the most frequent cause of otitis media in children under the age of two, it is unfortunate that the current vaccine fails to produce a satisfactory antibody response in this age group. Hopefully, vaccines and administration schedules currently under study may be more effective.

This polysaccharide vaccine (like the meningococcus vaccine) is safe and well tolerated and appears not to be associated with the Guillain-Barre syndrome. While pneumococcal vaccine is relatively expensive (\$8 to \$10 in the physician's office), it is effective for a period of five years.

Pneumococci resistant to penicillin and other commonly used antibiotics are being isolated from patients with increasing frequency, and an outbreak of infection with such organisms would prompt the widespread use of pneumococcal vaccine.

Epidemiologists have expressed concern that the elimination of the 14 common pneumococcal types from the community might result in an increase in infections due to less commonly encountered strains. Such a phenomenon has occurred in some instances with use of the meningococcal vaccine but has not been recognized in areas utilizing the pneumococcal preparation. It is important that some medical centers in the United States continue to type strains of pneumococcus to identify the emergence of new infecting strains. (The Wilmington Medical Center Microbiology Department types all pneumococci isolated from blood and spinal fluid cultures.)

Further studies are underway to enlarge the scope and efficacy of the pneumococcal vaccine. In the meantime, physicians are urged to utilize the current preparation for the protection of their patients at risk.

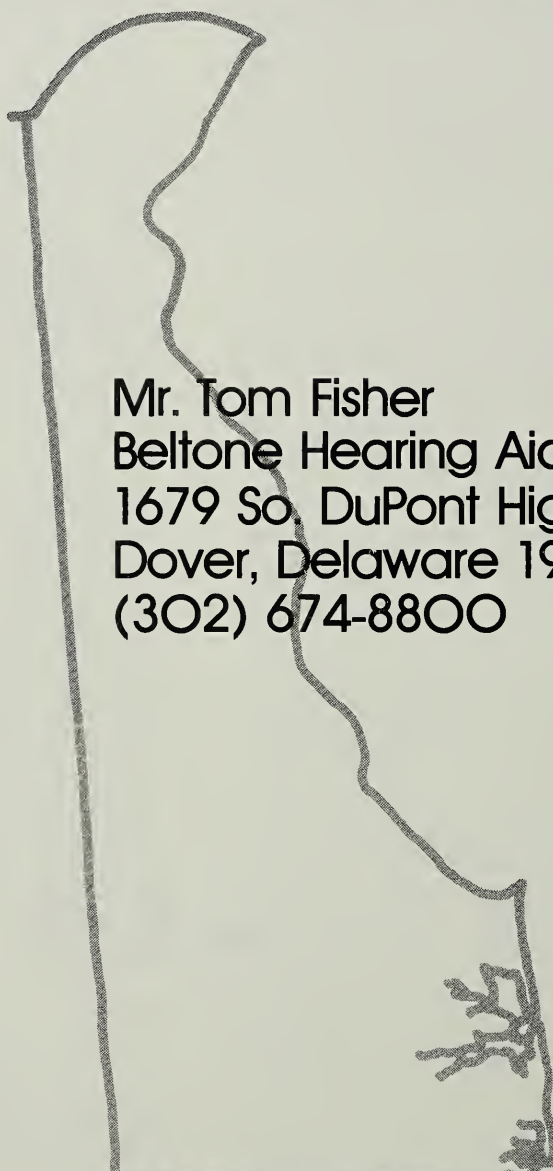
WILLIAM J. HOLLOWAY, M.D.

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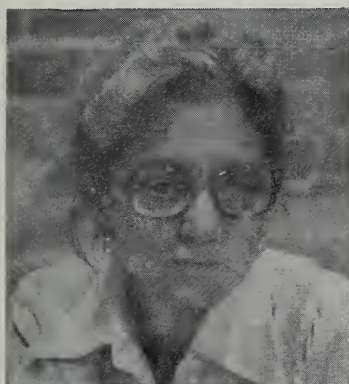
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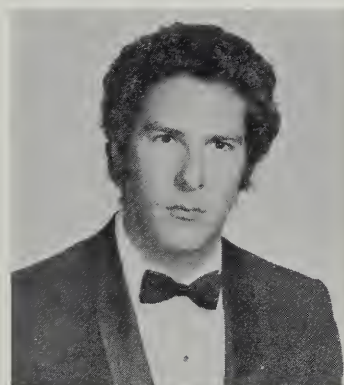
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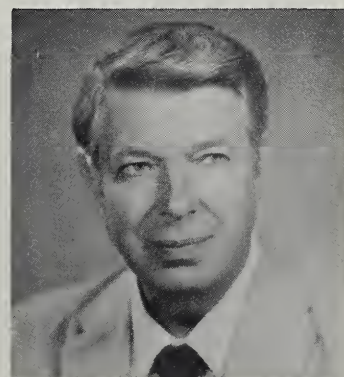
Dorothy Jean Flint, M.D., is a 1960 graduate of the University of Pennsylvania School of Medicine and interned at the Cleveland Clinic Hospital. She served a neurosurgical residency at the University of Pennsylvania and a psychiatric residency at Hahnemann. She previously practiced neurosurgery at the Spitz Clinic in Media, and in Philadelphia child and adult psychiatry. Dr. Flint is currently practicing child and adult psychiatry in Wilmington at 3509 Silverside Road. She is also the Head of the Outpatient Department at the Terry Children's Psychiatric Center in New Castle and is listed in *Who's Who in American Women* and *Who's Who in the East*.

Harry Martin Freedman, M.D., a native of Philadelphia, graduated from Autonomas University of Guadalajara, '72, and served his internship and residency at Hahnemann Medical College. Dr. Freedman specializes in orthopedics and is practicing at 801 Middleford Road, Seaford. Doctor Freedman lives in Seaford.



Sae-Il Chun, M.D., is a 1961 graduate of the Yonsei University Medical School, Korea. He interned at St. Agnes Hospital in Philadelphia and served his residency at the University of Pennsylvania Hospital. He was previously in practice at the University of Pennsylvania Hospital and Philadelphia General Hospital. He is currently practicing at the Delaware Curative Workshop at 1600 Washington Street, Wilmington, and specializes in physical medicine and rehabilitation. Dr. Chun lives in Woodbury, New Jersey, with his wife and three children. His hobbies include golf, table tennis, and travel.

Louis E. Gromadzki, M.D., is a 1958 graduate of the University of Pennsylvania School of Medicine and completed his internship at Pennsylvania Hospital and his residency at the University of Pennsylvania. He was previously in practice at the University of Pennsylvania School of Medicine and Philadelphia General Hospital. His current practice is located at 2300 Pennsylvania Avenue, Wilmington, and his specialty is neurology. Doctor Gromadzki lives in Greenville with his wife and two children.

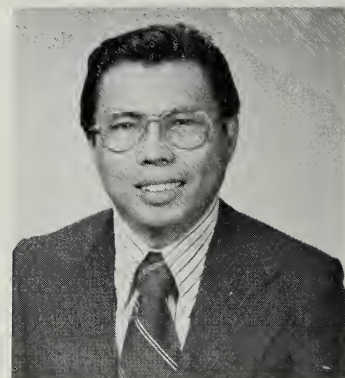


New Members



Stephen Schlesinger, M.D., graduated in 1970 from the State University of New York at Buffalo Medical School and served both his internship and residency at the Children's Hospital of Pittsburgh. He completed a fellowship in childhood and behavior before joining the pediatric practice of Drs. John Forest and Walter Omais at 1001 S. Bradford Street, Dover. Doctor and Mrs. Schlesinger live in Dover and have two children.

Margarito G. Granada, M.D., is a 1968 graduate of the University of Santo Tomas, Philippines, and interned at the Mt. Sinai Hospital Service and the City Hospital, Elmhurst, New York. Dr. Granada is board certified in internal medicine and pulmonary disease. He is a member of the American Thoracic Society, the American Society of Internal Medicine, and the New York Trudeau Society. Previously in practice in New York City, Dr. Granada is presently practicing at the Nanticoke Memorial Hospital in Seaford. He lives with his wife and two children at North Shores in Seaford.



Robert W. Patton, D.O., is a graduate of the Philadelphia College of Osteopathic Medicine, '55 and also completed his internship there. He served his residency in Psychiatry at the Philadelphia Mental Health Clinic and Haverford State Hospital. Dr. Patton was a general practitioner in Aldan, Pennsylvania, for ten years and is now a board certified psychiatrist. He is presently practicing at 1 Benton Court, Wilmington. This address is also his residence where he lives with his wife and three children. His hobbies are racquetball, tennis, sailing, and history.

Ramachandra U. Hosmane, M.D., graduated from the University of Bombay, India in 1963 and completed his internship at St. Luke's and Children's Medical Center, Philadelphia, Pennsylvania. He served his residency in urology at Hahnemann Medical College, also in Philadelphia. Dr. Hosmane was previously in practice in England; he is a fellow of the Royal College of Surgeons of Edinburgh. He is presently practicing at 3909 Highway One, Rehoboth, Delaware. He lives in Lewes with his wife and two young sons. His hobbies include reading history and English classics, Transcendental Meditation, tennis, table tennis, swimming, and bicycling.



Letters to the Editor

To the Editor:°°

I should have known I would be recognized.

I just never believed the *Sunday News Journal* (Delaware's Doctors—September 24, 1978) would send their ace of aces, Jane Harriman.

After all, it was only a Medical Meeting.

Although I was unaware of her presence, she evidently zeroed in on me as I wandered "kindly looking, simple, balding, middle-aged, wearing double-knits that betrayed my thickening waist."

Surrounded as I was by young, friendly, immaculately groomed physicians, how did I think I could get away with it?

Broad on my beam, but no broad on my arm (as had Robin Cook, M.D.) Jane tailed me. Indeed, I browsed through and picked over pamphlets labeled "Investment Plans," "Retirement Plans," and "New Drugs."

Suddenly, unmarried Robin Cook, M.D., "deli-

**To the Editor of the *Sunday News Journal*. This letter appeared therein on October 29, 1978.

cately built, long silky hair" distracted her, and I was free. Jane was awed by "the expensive French blue shirt, silk tie, Gucci pocketbook, perfectly tailored blue blazer, and beige pants" (holding his \$800,000 in one or both pockets?).

On I went, seeking out the 1978 Honor Men: Marvin H. Dorph, M.D. (the President's Award); Calvin B. Hearne, M.D. (the Distinguished Service Award); David Platt, M.D. (one of eight runners-up for the Good Housekeeping Award for 1978 Family Doctor of the Year) as well as the eight physicians being honored for 50 years of outstanding medical service to the community.

"Coma"-ed, Jane H. nibbled on two cookies, and thus had little or no space left for the real muscle building meat and vegetables.

After all, that is really what our Medical Society Meeting was all about, the muscle building meat and vegetables.

I'm sorry that Jane got hooked by a couple of cookies.

CHARLES M. BANCROFT, M.D.

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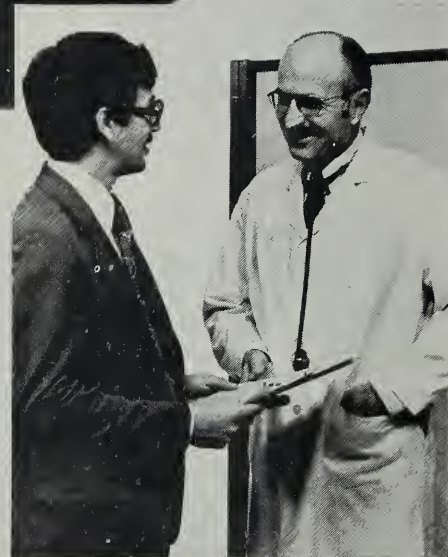
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Deaths

NORMAN L. YOOD, M.D.

Dr. Norman L. Yood, 64, of Media, Pennsylvania, retired radiologist and also a retired Captain (Medical Corps) of the US Navy, died August 29, 1978.

Dr. Yood, a graduate of Harvard College (1935) and Columbia University College of Physicians and Surgeons (1939), was commissioned in the Navy as a Lieutenant (j.g.) M.C. in 1941.

He attended the US Navy School of Aviation Medicine from December, 1941, through April, 1942, and was a designated Naval Flight Surgeon assigned to the First Marine Air Wing in the South Pacific during the Guadalcanal campaign. He was one of three Navy Flight Surgeons who instituted the air evacuation of casualties when surface ships could not reach Guadalcanal.

As Flight Surgeon assigned to the transcontinental unit of Naval Air Transport Service, he helped form a transcontinental hospital plane service to move casualties in the naval hospitals closer to their homes.

Additional duty stations were the Staff of Commander, Naval Air Transport Service; Senior Medical Officer at Naval Air Station, Pearl Harbor; at the Naval School and air station in Monterey, California; and on carrier duty in the Atlantic and the Mediterranean.

Dr. Yood was awarded the Distinguished Flying Cross, the Air Medal with three stars, Presidential Unit Citation, and Navy Commendation, among others.

In the early 1950's he was a Fellow in the

Department of Radiology under Eugene Pendergrass, M.D., at the Hospital of the University of Pennsylvania, and he attended the Graduate School of Medicine there. He was Chief of Radiology at the US Naval Hospital, Philadelphia. He was an instructor at the University of Pennsylvania School of Medicine.

Retiring from the US Navy in November, 1961, he served as radiologist in Philadelphia, Lebanon, and Chester, Pennsylvania.

In 1970 Dr. Yood became an associate in the private practice of radiology in Wilmington, Delaware, with Doctor Christos Papastavros. In 1973 he became the radiologist at the Alfred I. duPont Institute, retiring in September, 1977.

He was a Fellow of the American College of Radiology, a member of the Philadelphia Roentgen Ray Society, the Pennsylvania Radiology Society, the Radiological Society of North America, Pennsylvania and Delaware County Medical Societies, New Castle County Medical Society, the Medical Society of Delaware, and the American Medical Association. Dr. Yood served as a ruling elder in the Media Presbyterian Church.

Dr. Yood is survived by his wife, the former Sheila Hazel Fisher-Smith, an Australian, whom he met and married in Sydney, Australia in 1943; three sons, Richard of Milwaukee, Wisconsin, Robert, of Delran, New Jersey, and David, of Atlanta, Georgia; one daughter, Mrs. Leslie Bloxhan of North Carolina; four grandchildren; and one brother, Harold.

Memorial gifts may be made to the donor's favorite charity.

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Book Reviews

AND A TIME TO LIVE TOWARD EMOTIONAL WELL-BEING DURING THE CRISES OF CANCER

by Robert Chernin Cantor, DMD, Ph.D., Harper & Row, Publishers, Inc., Hagerstown, Maryland, 1978. 280 pp. Price \$9.95.

Despite many advances in the understanding and treatment of cancer, the thought and image of this disease terrifies and frightens more than any other. The personal/emotional and family/social experiences of the cancer patient are as real as the disease and treatment itself, and it is becoming increasingly clear that these factors have a tremendous influence upon the course and outcome of the disease.

A Time to Live is intended as a resource for patients and health professionals to give an understanding of the impact of the diagnosis of cancer and of the many conflicts that emerge within the individual and within his family and social relationships in response to that diagnosis. By understanding these conflicts as normal and "workable," the patient is encouraged to "go for life."

The book is divided into four major sections. The first section, "The Cancer Experience," identifies three of the most common sources of anxiety for cancer patients: 1) a sense of losing control; 2) a fear of being abandoned; and 3) the identification of cancer with that which is evil or disowned about oneself, society, and one's culture. A discussion of depression and anger, grief, and mourning is also included.

In the second section of the book entitled, "Sphere of Personal Influence," the author stands very firmly next to the patient. What he considers one of the most important treatment issues is how the patient views and responds to his diagnosis. The management of the cancer crisis is a process of individual and family adaptation. Successful adaptation includes the acquisition of information about the disease and treatment processes at a pace that allays anxiety, it includes the establishment of sufficient emotional stability to deal with the stress of the disease, and it in-

cludes the ability to maintain the sense of personal authority and participation in the treatment process. Cantor takes the reader into current synergistic studies in humanistic medicine, psychology, sociology, and theology and states that "healing occurs when an alliance takes place between the physician's skills and the patient's inner healing potential." (p. 131)

The third section of the book represents one of the finest pieces of work I have seen in the application of what we know about family structures and dynamics to the matter of cancer diagnosis. One can "hear" the many hours of listening that the author has done with patients and their families as he outlines four kinds of marital relationships and shows how the cancer diagnosis impacts each of these.

The cancer crisis is rarely a time of radical change, but it often becomes an optimal time for a person to become more aware of values and meanings in his life. The discovery of meaning is not a sudden "aha!" experience. Rather, meaning emerges through the realistic struggle with loss, pain, confusion, and meaninglessness. In the fourth section of the book, Cantor is very supportive of the faith and belief held by patients and writes this chapter to help health professionals appreciate the importance of religious belief and humanitarian concern as a means by which the patient can gain a fuller sense of life.

Throughout, the author attempts to avoid technical and scientific jargon and uses many helpful vignettes to share the enormous amount of personal experience he has had with cancer patients and their families. A few of his references are not as up-to-date as one would wish, but again, the matters he is addressing have not enjoyed widespread publication to date. I was surprised, for example, by his reference to "most doctors (80% in one study) elect not to tell the truth even when patients ask if they have cancer." (1953 and 1961) I think significant changes have occurred in this area which are not sufficiently taken into account by these references.

Book Reviews

And A Time to Live provides useful reading for anyone who wants to learn more about the personal and family dynamics that play a part in the course and outcome of the disease, cancer.

CARL R. SACHTLEBEN

Mr. Sachtleben is Coordinator of Pastoral Services for the Delaware Cancer Network.

A QUESTION OF QUALITY? ROADS TO ASSURANCE IN MEDICAL CARE edited by **Gordon McLachlan**, Oxford University Press, New York, 1976. 297 pp. Price \$19.75.

This book is a collection of essays by a multidisciplinary group of contributors on the state of health care in the United Kingdom. The editor, a prolific writer on related subjects, is the secretary of Nuffield Provincial Hospitals Trust. The submitted reports by the representatives of hospitals, medical schools, and the medical profession deal with evaluation of quality and ongoing efforts to upgrade it. A chapter devoted to the situation in the US is included.

Established in 1948, the National Health Service (NHS) has been providing medical care to all on the basis of need, without regard to the ability to pay. The periodic inspections and reports yield a suitable framework for the monitoring and study of health care. Since its inception the NHS has had its ups and downs. Legitimate complaints have been related to red tape, the long waiting lists for surgery, and the doctors' unavailability for emergency calls. Repeated corrective action by the government has brought about reorganization and other steps. The Hospital Advisory Service sends teams of experts to trouble spots, combining investigation with education of personnel. In the scrutiny of the strengths and weaknesses of programs the following criteria have been used in most cases: (1) medical effectiveness, (2) social acceptability (this lumps together such items as adequacy of hospital appointment systems, doctor-patient relationship, etc.), and (3) economic efficiency. To improve the standards of medical practice, educational allowances and other incentives have been introduced. Postgraduate

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Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdose. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in the evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in the morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdose include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdose.

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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training is now a prerequisite for appointment to higher paid supervisory positions. Assignment of a young physician to an experienced general practitioner for a period of one year was a favored method of training some years ago. It has fallen into disrepute because of variations in the quality of the individual preceptors. General practice in England, as in the US, is now an accredited specialty. Examination and certification are available through the Royal College of General Practitioners.

In the United States the medical profession is engaged in several quality assurance activities, most of them voluntary. Not the least motivating factor is the deterrent of malpractice litigation which a few years ago assumed crisis proportions. Comprehensive national health insurance has been so far successfully delayed with the backing of the doctors' powerful lobby, the AMA.

With all its shortcomings and contrary to the belief of many in the US, the NHS continues to enjoy the support of the British community, including most of the physicians. The answer, in my opinion, lies in the higher level of social consciousness of the British, a considerable sensitivity to public vs private benefit, or, as the editor puts it, "the acting for the common good."

The editor of this challenging work deserves credit for his thoroughness and dedication. Commenting on the validity of methods of assessing quality, he stresses the need for further research. This volume can be recommended to those engaged in the study of health care delivery. While the scene is British, the scope is universal.

ABRAHAM VINOGRAD, M.D.

COLLECTING DATA FROM PATIENTS by **George A. Wolf, Jr., M.D.**, University Park Press, Baltimore, 1977. 275 pp. Paperback. Price \$12.95.

The title really doesn't suggest that this is a book on physical diagnosis, but it is. What need is there, if any, to print another text on this subject? There are many excellent ones available, and the basic techniques have not changed appreciably in 50 years. Evidently, Dr. George Wolf thought that he could do it better. In some

areas he succeeds. His comments on approach to the patient are excellent as are his "patient profile," his concise discourse on problem-oriented records, and the illustrated section on the neurologic exam. He betrays his medical (as opposed to surgical) background by giving the abdomen only a very brief and superficial discussion, advocating one-handed palpation, devoting a single sentence to rebound tenderness and no mention at all of skin hyperesthesia. Yet in the chest section he tells about mapping out Grocco's triangle, which is about as futile and impractical an exercise as I know of. His mathematical approach to reaching a diagnosis is an interesting change from the usual branching logic concept, though not too helpful to my way of thinking. He winds up with a few pages on audit, a subject we all should know more about.

All in all, an easily read book with several good sections.

E. WAYNE MARTZ, M.D.

CLINICAL NEUROENDOCRINOLOGY by **Joseph B. Martin, M.D., Seymour Reichlin, M.D., and Gregory M. Brown, M.D.**, F. A. Davis Company, Philadelphia, 1977. 410 pp. Illus. Price \$30.00.

In 1977 the Nobel Prize in medicine was awarded to several researchers for their work in the development in the technique known as radioimmunoassay. Before the perfection of this technique only major alterations of hormonal levels were possible. Almost as a tribute to the occasion, Drs. Martin et al published *Clinical Neuroendocrinology* in the same year. This volume is No. 14 in the now well-known "Contemporary Neurology Series," made famous by an earlier volume on "Stupor and Coma" by Drs. Plum and Posener.

The book is divided into three major areas. The first is a relatively short (approximately 60 pages) but well-done overview of the subject (all you ever wanted to know about neuroendocrinology in one hour). The second goes into depth in discussing the various hormones and hypothalamic releasing factors and inhibitors.

The third, a more clinically-oriented section,

discusses such subjects as "Neurologic Manifestations of Hypothalamic Disease," the "Clinical Approach to Diagnosis of Hypothalamic Pituitary Disease" (from the neurologic and endocrinologic aspects), and "Treatment of Disease of the Hypothalamic Pituitary Axis." In the diagnostic section, a cookbook approach is taken which should be quite useful to those frequently involved with patients presenting with endocrinologic abnormalities. In a chapter entitled "Effects of Hormones on the Brain," some of the newer work involving peptides widely distributed in the nervous system is briefly described. Much of this work and especially the work on endorphins, learning peptides, and substance P have recently received much attention in the lay press.

This volume is extremely well done and should be quite useful to most internists, pediatricians, endocrinologists, and neurologists as well as others exposed to patients with disorders of the hypothalamic pituitary axis.

LANNY EDELSON, M.D.

TOGETHER A CASEBOOK OF JOINT PRACTICES IN PRIMARY CARE edited by Berton Reueche, The National Joint Practice Commission/Educational Publications and Innovative Communications, Chicago, 1977. 257 pp. Price \$5.95.

The National Joint Practice Commission—the joint practice being between nurses and physicians—was established with the aid of a large grant from the Johnson Foundation. It is an AMA-approved organization (I do not know if some of its financial support is also from the AMA) and holds at least one joint annual meeting with physicians. This book, edited by the best medical writer in the business, Berton Roueche, whose pieces on Cushing's disease, asbestosis, and other medical problems have appeared in *The New Yorker* for many years, is a breezily written description of how, with the blessings of the physicians with whom they are in joint practice, many nurses are now actually providing medical care superior to any which their patients previously experienced.

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The nurses are more pleasant, which engenders better patient rapport. Their skill at handling "ordinary" medical problems is praised, and the tribulations these nurses go through when some not-yet-enlightened physicians object to their practicing medicine lamented. In the joint practices described, the nurses do about what they wish. In most instances, the charge to the patient is the same as if the patient had seen a physician; in a few it is a bit less despite the fact that the nurses usually take more time with their patients to make them feel loved and secure and to be sure that all the social problems have been discussed. These nurses do a marvelous "feeling" job according to these examples, and the doctors with whom they are associated have great faith in them and couldn't hack it without them.

Several of the nurse practitioner/physician teams described in this book are also husband and wife. The nurse/wife in one explains that the doctor/husband always cleans up any mess he makes during a procedure or else she just leaves it until he gets around to cleaning it up.

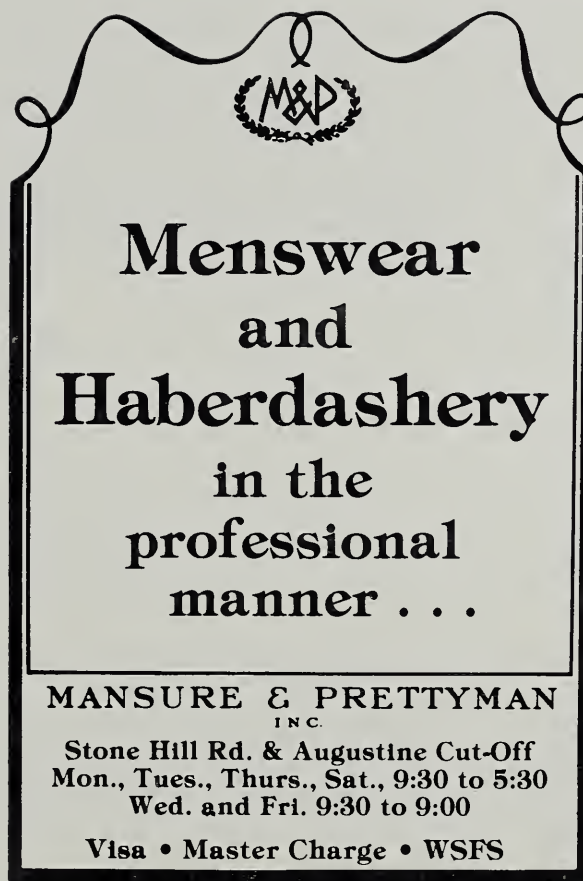
Some of the memorable quotes: "I don't work for him, I work with him," says Ms. Tucker, nurse practitioner, about Dr. Dickey, presumably her employer. "Bob empties the trash and cleans up a room after a child throws up. If he sees a baby, he does everything himself. He weighs the baby, gives it shots, and explains things to parents."

Mary Zako works in association with her husband, who says, "The American concept is that a doctor is God's assistant and he knows everything. We've got to change that." He's doing his bit by having his wife Mary, a nurse, join him to "do routine physical examinations and counsel patients," although she seems a bit restive to me already.

"I don't want to get into an assembly line routine of not doing anything but Pap smears," she says.

Sharon Pattee got her job as a nurse assistant because while working in the front office, she "saw what they (the internists) were doing and I wanted to be part of it."

If nurses are as good as this book says, half



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of the medical schools in this country are unnecessary and all of the generalists. Why are we requiring doctors to go to three or four years of medical school after college and then for three or more years postgraduate work in residencies? These teams seem to be saying that for most everything a nurse is nicer—maybe, but not necessarily, cheaper—but certainly nicer and just as good. Today joint practice, tomorrow—?

The federal government has recently announced it will pay nurses directly for primary care of patients in doctor-short neighborhoods. I predict a lot of upcoming battles.

BERNADINE Z. PAULSHOCK, M.D.

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THE HITE REPORT A NATIONWIDE STUDY OF FEMALE SEXUALITY by Shere Hite, Dell Publishing Company, Inc., New York, 1976. 638 pp. Price \$2.75. Paperback.

According to the various publishers' press releases that accompanied this book, trumpeting

its praises, the book is "... wonderful ... the most meaningful book they have ever written on female sexuality ... classic ... a joy to read ... wonderful emotional quality." Extracts from critical commentaries from several periodicals also sing the praises of author and book ... "the most important book on female sexuality since ... Masters and Johnson ... the most important study since Kinsey's ... a bombshell."

The public relations department also notes that few reviewers have managed to completely grasp the material and to describe the new views of sexuality the book contains. In view of the lavish praise heaped upon the book and author by so many reviewers, it would appear that quite a few of them got something out of it. Exactly what may be questioned.

As to the data base used by Ms. Hite, it consists of a series of four questionnaires sent out or published in various magazines between September, 1972, and March, 1974. Differences are noticeable in each questionnaire (these are included in the book) so it is reasonable to assume

that not everyone answered the same questions. In addition, people replying to the questions did not have to answer all the questions, just the ones that they wanted to. The author states that over 100,000 questionnaires were sent out. Only about 3,000 replies were received, however, a figure of about 3%. While 3,000 is a fairly large number, the fact that the forms varied to some extent would tend to lower the representative responses to less than this. Furthermore, while replies from the fourth questionnaire are included in the book, they are not counted in the statistical series, leaving 1,844 responses, and resulting in a response rate of about 1.8%.

Now we arrive at the text itself. The selected responses to the various questions presented may perhaps be best represented as those found in some of the more delicate gentlemen's magazines presently to be found behind the newsstand, not the worst of which is that publication for which the author posed in the recent past.

This reviewer deprecates the author's opinion that she has gathered the opinions and understands the whole truth about female sexuality. Kinsey in his time sphere and Masters and Johnson have done outstanding work, more scientific and simply better done.

The final statement is taken from publicity releases accompanying the reviewer's copy. "Although never intended as a statistically representative survey of women in the US, Hite ... has generalized to some degree from her findings. A discussion of her methodology will be published in the near future." The time to discuss methodology is when the statistics are presented and not at some future time so that readers themselves may better determine the validity of any conclusions or figures offered. And if it is not intended as a statistically representative survey, why is it presented as one?

1977 CURRENT THERAPY, edited by **Howard F. Conn, M.D.**, W. B. Saunders Company, Philadelphia, 1977. 986 pp. Illus. Price \$24.50.

There are few books that are updated with sufficient regularity to serve as a general reference source allowing the practicing physician to keep up with the very latest methods of treat-

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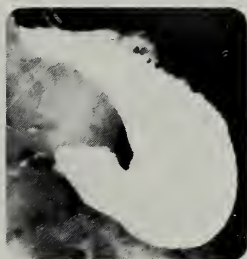
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"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating certain functional G.I. disorders.

[†]See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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INDICATIONS

For use as adjunctive therapy in the treatment of peptic ulcer. IT SHOULD BE NOTED AT THIS POINT IN TIME THAT THERE IS A LACK OF CONCURRENCE AS TO THE VALUE OF ANTICHOLINERGICS/ANTISPASMODICS IN THE TREATMENT OF GASTRIC ULCER. IT HAS NOT BEEN SHOWN CONCLUSIVELY WHETHER ANTICHOLINERGIC/ANTISPASMODIC DRUGS AID IN THE HEALING OF A PEPTIC ULCER, DECREASE THE RATE OF RECURRENCES, OR PREVENT COMPLICATION.

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders); and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon).

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloro-duodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: autonomic neuropathy; hepatic or renal disease; ulcerative colitis—Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon; hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension; hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis). Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSEAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: Adults: 1 or 2 capsules or teaspoonfuls syrup three or four times daily. Children: 1 capsule or teaspoonful syrup three or four times daily. Infants: ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: Adults: 1 tablet three or four times daily. Bentyl Injection: Adults: 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. **MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of October, 1976

ment. An attempt to stay abreast of current developments by reading the many medical journals available quickly buries even the most industrious of physicians. What is needed is a text that would enable the physician to devote more of his time to his family and patients than to an ever increasing pile of magazines.

The present *Current Therapy* does just what it should—provide the current methods of accepted therapy without frills and advertisements. The stated aim of Dr. Conn, in his preface, is "to continue the policy of keeping pace with the rapidly changing therapeutic methods from all over the world and bring them to the practicing physician."

This is not a text aimed at treating exotic diseases, but rather the problems encountered on a frequent basis by the general practitioner or internist. The diagnostic procedures may be briefly mentioned, but the treatment protocol is discussed in detail.

The size of the type and the non-glare paper make the text comfortable to read. It is well organized, being arranged by organ system or major topic. Admittedly, not every possible problem can be discussed, but those that are done are done well.

Reading the yearly editions of *Current Therapy* is one way that the busy practitioner can keep abreast of current treatments and standards in therapeutics.

ETHAN G. FLAKS, M.D.

THE QUALITY OF MEDICAL CARE: EVALUATION AND IMPROVEMENT by Beverly C. Payne, M.D. and Study Staff, Hospital Research and Educational Trust, Chicago, 1976. 157 pp. Paperback, Price \$8.00.

This book reports a thoughtfully planned and carefully executed study of an evaluation of the quality of medical care in Hawaii. Over 40% of the book is appendix, listing criteria for care, questionnaires, and similar study instruments. The text is rather short and liberally sprinkled with tables and graphs. In spite of my own bias

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that most doctors do a pretty creditable job, Dr. Payne is very persuasive in presenting the case that things could be better. Her statistics indicate rather consistently that prepaid group practice provides the best care, followed by fee-for-service groups, and that solo practice suffers by comparison with either. She presents some interesting insights. For example, the study attempted to correlate good care with good outcomes, but found that the more complex or severe the illness, the more meticulous and careful the doctor becomes. Thus the best care correlates with the worst outcomes. Likewise, the most competent specialists are referred the worst problems so they tend to have a dismal proportion of treatment failures.

The study clearly indicates that the selection of criteria is all important, yet there is very little discussion of this aspect of evaluation. When they faithfully report that 42.2% of acute cholecystitis patients overstay their hospitalization and 83.5% of previously diagnosed diabetics understay, it should be obvious to anyone that the

fault does not lie in the hospital stay but in the norm they have chosen. Finally, with all the hue and cry about quality of medical care, nowhere do I find the slightest mention of that old marketing truism that more important than quality of product is customer satisfaction. The two usually go together, but not always.

E. WAYNE MARTZ, M.D.

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CHILD ABUSE: PERSPECTIVES ON DIAGNOSIS, TREATMENT, AND PREVENTION edited by Roberta Kalmar, Kendall/Hunt Publishing Company, Dubuque, Iowa, 1977. 150 pp. Price \$5.95. Paperback.

This 150-page paperback is one of 13 titles in the "Topics in Human Behavior" series under the general editorship of Gary S. and Melanie C. Belkin. All of the 12 papers collected here appeared originally in the psychiatric, psychologi-

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cal, or social work literature between 1965 and 1975. As the title implies, the papers represent varying approaches or viewpoints to the problem of the abused or neglected child. Most begin in the traditional fashion with a review of the earlier literature on the subject, which gained impetus from the widely read papers of Elizabeth Elmer (1960) and of Dr. Henry C. Kempe et al in JAMA (1962). This leads to repetitiousness and redundancy which might have been reduced by judicious editing.

A few salient points appear, therefore, several times:

- (1) Child abuse may occur in affluent as well as deprived family groups.
- (2) The abusing parent is sometimes, but not always, disturbed or psychotic.
- (3) Abuse is often limited to one of a group of siblings.
- (4) The marital partner of the abusing parent usually conspires to protect the abusing

parent, even when he or she does not actively participate.

- (5) Investigation of the psychodynamics of the family situation often shows a striking "role reversal"; the abusing parent perceives the child as either failing to support and nurture the parent, or as a source of evil and an actual threat to the parent. This rather bizarre thought pattern may gain some credence from the recent series of motion pictures which portray a child as having supernatural powers to bring destructive forces to bear upon a parent.

The treatment modalities set forth by the various authors relate to the disciplines which they represent. It would appear that any of several approaches may be beneficial, largely dependent on the local availability of appropriate counselling. Several authors have had good experiences with "Parents Anonymous" groups, of which there are now more than 450 nationwide. This might be predicted from the conclusion

drawn by all contributors to this volume that the abusing parent is typically a "loner" who has few family and group relationships. The thrust of preventive efforts is to reach out to these parents and keep them involved in other relationships so they need not invest abnormal significance in their child.

WILLIAM L. SPROUT, M.D.

❖ ❖ ❖

PULMONARY PATHOPHYSIOLOGY THE ESSENTIALS by John B. West, M.D., Ph.D., The Williams & Wilkins Company, Baltimore, 1977. 227 pp. Price \$9.95. Paperback.

This is a paperback book of excellent quality. It is printed on a good grade paper, the illustrations are appropriate and clearly presented, and

it accomplishes its purpose of presenting the essentials of its subject. This is a book which is highly recommended for medical students, house-staff, and for any physician who would like a primer on the pathophysiology of pulmonary diseases.

The book is divided into four major sections. Section I is on "Lung Function Tests and What They Mean." This section is divided into chapters on ventilation, gas exchange, and other tests. This last consists of tests of more sophisticated lung function, ie, static lung volumes, airway resistance, control of ventilation, exercise tests, and a discussion of dyspnea.

Section II is titled "Function of the Diseased Lung." There are chapters on obstructive diseases, restrictive diseases, vascular diseases, and other diseases. The other disease category includes discussions on atmospheric pollutants, the disposition of the aerosols in the lung, clearance

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of deposited particles, pneumoconioses, and malignant and infectious diseases. The format used is typical of the book as a whole. There is a brief discussion of the pathology, etiology if known, and some clinical features, and then a detailed section on the applicable pulmonary functional abnormalities follows. I find this to be an excellent method of presentation when the reader is seeking information on a specific disease.

Section III deals with "Function of the Failing Lung." The three chapters in this section are on respiratory failure, oxygen therapy, and mechanical ventilation. The last chapter would be particularly valuable for those physicians involved with the care of patients on ventilators even though they are not primarily responsible for ventilator management.

Section IV contains a list of symbols used in respiratory physiology, a table of normal values, references used in the book, a list of suggested reading, and a section of questions and answers. The index is small but adequate.

LEONARD P. LANG, M.D.

❖ ❖ ❖

HYPERTENSION MECHANISMS, DIAGNOSIS & MANAGEMENT edited by James O. Davis, M.D., John H. Laragh, M.D., and Amy Selwyn, H&P Publishing Company, Inc., 1977. 274 pp. Illus. Price \$18.95.

There really is more to hypertension management than screening in supermarket parking lots and glibly prescribing a "no salt" diet and a daily thiazide pill to be taken "forever."

This skillfully edited book (the chapters were all previously in *Hospital Medicine* before being assembled in this collection) includes excellent presentations by everyone who is anyone in the blood pressure business. Since at present hypertension epidemiologists insist that 16% of American adults are hypertensive, hypertension is a big business. Furthermore, if it is confirmed by

repeated studies that a diastolic pressure as high as 95 mm Hg increases mortality rate two and a half times in men aged 35 to 45, essential hypertension is obviously not benign!

The 23 chapters in this compendium separately review the pathogenesis of essential and endocrine hypertension as well as pragmatically discuss the evaluation and management of hypertension in children, contraceptive pill hypertension, etc. Although there is no attempt to integrate the individual chapters, on the whole the book is a high quality resume of current research and therapy at a reasonable price.

KATHLYN OBERLY, R.N., M.S.N.
BERNADINE Z. PAULSHOCK, M.D.

❖ ❖ ❖

CURRENT THERAPY 1978 edited by Howard F. Conn, M.D., W. B. Saunders Company, Philadelphia, 1978. 947 pp. Price \$25.50.

This work is the thirtieth in an annual series designed to bring brief, to-the-point therapeutic methods to the practicing physician. As in previous editions, most of the articles have been newly written; some ninety-two per cent are by authors new to the current volume. *Current Therapy* is not intended as a complete reference work for the physician researching a topic in depth; rather, its greatest utility would seem to be as a desk-top source for the busy internist or family practitioner in situations of unfamiliar drug applications or dosages.

Of particular interest are sections dealing with topics "peripheral" to general medicine such as dermatology, OB/GYN, psychiatry, and toxicology. The practical advice given in these diverse fields is seldom found under one cover. The reliance on one source, on the other hand, bypasses many of the controversies in current medical therapy in such fields as antibiotic selection or cancer chemotherapy. *Current Therapy* is a useful, relatively up-to-date source covering a broad range of medical therapeutics.

EDWARD J. McCONNELL, M.D.



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For information: DR. PATRICK S. PASQUARIELLO, JR., Director of Continuing Education, The CHILDREN'S HOSPITAL OF PHILADELPHIA, One Children's Center, 34th and Civic Center Boulevard, Philadelphia, Pennsylvania 19104.

COSMETIC FACIAL SURGERY by Thomas D. Rees, M.D. and Donald Wood-Smith, W. B. Saunders Company, Philadelphia. 609 pp. Illus. Price \$65.00.

The one area in plastic surgical residency training that has been neglected in the past and that continues to be a stepchild is the area of aesthetic plastic surgery. The majority of medical center and university training programs in plastic surgery have other surgical priorities and do not emphasize this area of plastic surgical endeavor. Furthermore, it is only in recent years that the high premium on physical appearance has been recognized as an area of worthwhile endeavor, and as such, most of the work has been done in either private or more suburban-oriented institutions.

Since it takes years of experience to assemble a degree of aesthetic plastic surgical competency, the authors have by combination of drawings and excellent preoperative and postoperative photography detailed the multiplicity of procedures

available and outlined diagnosis and treatment with painstaking attention to detail.

There is excellent coverage on patient selection as well as the multiplicity of social and psychologic considerations, including the mainstays of facial cosmetic surgery. The problem areas are especially well covered and multiple pre- and postoperative photographs illustrate the context and salient points extremely well.

PETER R. COGGINS, M.D.

CORRECTION

In the review of *Essentials of the Neurological Examination* printed in the October 1978 issue one author's name was incorrect. The review should have read, "by Bernard J. Alpers, M.D. and Elliott L. Mancall, M.D.," not Elliott L. Marshall.

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In Brief

Speakers on "Ask the Doctor"

Speakers for December, 1978 on the Tuesday radio program (11:05 a.m., WDEL) produced by the Medical Society of Delaware are: December 5, *Richard T. D'Alonzo, M.D.*, Knee Injuries; December 12, *J. Jordan Storlazzi, M.D.*, Learning Disabilities; December 19, *Gary M. Owens, M.D.*, Arthritis and the Family Doctor; December 26, *Marvin H. Dorph, M.D.*, Diabetes.

In the News

John W. Howard, M.D., Lewes, has been granted the status of Emeritus Fellow by the College of American Pathologists and Emeritus member by the American Society of Clinical Pathologists.

The following physicians have been elected to the Board of Directors of the American Heart Association of Delaware, Inc.: *Richard H. Morgan, M.D.*, Wilmington, Chairman of the Board; *Paul Pennock, M.D.*, Wilmington, Senior Vice-President; *Robert E. Heckman, M.D.*, Dover; *William D. Shellenberger, M.D.*, Wilmington, and *Helmi El-Ramli, M.D.*, Hockessin, Directors. *Mark G. Cohen, M.D.*, was elected to Honorary Board status. *E. Wayne Martz, M.D.*, serves as liaison to the Medical Society of Delaware.

Financial Plan Seminar

A Financial Plan Seminar sponsored by the Medical Society of Delaware will be held at the Wilmington Country Club on January 15, 1979 at 7:30 p.m. The speaker will be *Nicholas C. McDaniel, Esquire*, Vice President of Financial Planning Services, Dean Witter Reynolds, Inc.

CLINICAL NOTICES AND MEETINGS

ACP Meetings

The following meetings, which fulfill Category I requirements for the AMA Physician's Recognition Award, will be presented by the American College of Physicians.

SOUTH CAROLINA REGIONAL MEETING, March 16-18, Kiawah Inn (Kiawah Island), Charleston, South Carolina. For information contact: *Clarence W. Legerton, Jr., FACP*, Medical University Hospital, Charleston, South Carolina 29401.

For information on the following, contact: Registrar, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

NEUROLOGY FOR THE INTERNIST, March 5-8, Mayo Clinic, Rochester, Minnesota.
PROBLEM SOLVING IN GASTROENTEROLOGY, March 7-9, Scott and White Memorial Hospital, Temple, Texas.

PULMONARY MEDICINE—UPDATE 1979, March 14-16, University of Colorado at Denver.

UPDATE IN INFECTIOUS DISEASES, March 21-23, Medical College of Pennsylvania, Sheraton Hotel, Philadelphia, Pennsylvania.

CLINICAL RECOGNITION AND MANAGEMENT OF HEART DISEASE, DRUG THERAPY, March 22-24, University of Arizona, College of Medicine.

COMPLICATIONS OF UREMIA, April 2-6, U.S. Army Institute of Surgical Research and Brooke Medical Center, La Mansion del Norte Hotel, San Antonio, Texas.

DIAGNOSTIC AND THERAPEUTIC CONCEPTS IN ENDOCRINOLOGY, April 23-27, Mayo Clinic, Rochester, Minnesota.

ADVANCES IN THE THERAPEUTICS OF INTERNAL MEDICINE, April 25-27, University of Kentucky School of Medicine, Hyatt Regency Center, Lexington, Kentucky.

**Early
Intervention**

The Alfred I. duPont Institute will present a CONFERENCE ON EARLY DEVELOPMENTAL INTERVENTION, December 1-2, A. I. duPont Institute, Wilmington, Delaware. For information contact: Paula J. Malone, Ph.D., Coordinator, Child Development Center, A. I. duPont Institute, P.O. Box 269, Wilmington, Delaware 19899. Telephone: (302) 571-1000.

**Forensic Medicine
and Society**

The American Society of Law & Medicine and the Pittsburgh Institute of Legal Medicine will present the NATIONAL CONFERENCE ON FORENSIC MEDICINE AND SOCIETY, January 25-27, Hotel del Coronado, San Diego, California. The conference is open to all physicians, attorneys, forensic medicine specialists, pathologists, law enforcement personnel, legislators, and others interested in gaining an increased awareness of the various aspects, needs, and capabilities of forensic medicine in its broadest sense. For information contact: American Society of Law & Medicine, "Forensic Medicine and Society," 454 Brookline Avenue, Boston, Massachusetts 02215.

**ACS National
Conference**

The American Cancer Society will present the NATIONAL CONFERENCE—UROLOGIC CANCER—1979, April 4-6, Los Angeles Hilton Hotel, Los Angeles, California. The program is approved for 15½ Category I credits towards the AMA Physician's Recognition Award. For information contact: Urologic Cancer Conference, American Cancer Society, 777 Third Avenue, New York, New York 10017.

**Management in
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The New Orleans Graduate Medical Assembly presents MANAGEMENT OF COMMON PROBLEMS IN OFFICE PRACTICE—UPDATE, April 27-May 1, The Fairmont, New Orleans, Louisiana 70112. For information contact: Ms. Lois Neary, Executive Director, The New Orleans Graduate Medical Assembly, 1430 Tulane Avenue, New Orleans, Louisiana 70112.

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**Surgical Intensive
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The University of Miami School of Medicine, Departments of Anesthesiology and Surgery will present the SEVENTH ANNUAL SURGICAL INTENSIVE CARE SYMPOSIUM, May 4-7, Eden Roc Hotel, Miami Beach, Florida. The program is approved for 20 hours' credit. For information contact: Division of Continuing Medical Education, D23-3, University of Miami School of Medicine, P.O. Box 016960, Miami, Florida 33101. Telephone: (305) 547-6716.

CLASSIFIED AD SECTION

Advertisements under the Classified Ad Section are charged at the rate of 30 words or less, set solid. One insertion \$4.00. Call the Journal office, 658-7596 for further information or placement. All advertisements are payable in advance. The Editorial Board reserves the right to edit copy. Closing date for new copy is the first of the month for inclusion in the current issue.

Classified advertisements of a professional nature are free to members.

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cancer communiqué

FROM THE DELAWARE CANCER NETWORK*

DELAWARE CANCER REPORTING SERVICE

ELIZABETH A. AHLSCHIER, R.R.A.

The Delaware Tumor Registry during the last year has undergone a transitional period, becoming the Delaware Cancer Reporting Service. This transition involved the redevelopment of the State registry creating a more accurate data base. The Delaware Cancer Reporting Service includes not only the Delaware Registry but also all the data needs of the Delaware Cancer Network.

Mr. Abdul Nisar, a statistician with the School of Nursing, University of Delaware, is spending his sabbatical with the Network and has been involved in computer programming and providing technical assistance in eliminating the duplications existing in the Delaware Registry. This means that there is now a clean State registry which will make meaningful statistical studies possible. While each hospital will still retain the uniqueness of its own registry by maintaining its own computer information, an accurate and comprehensive data base for program planning is now available.

With Mr. Nisar's assistance it was possible to eliminate an error rate of 13 percent. The data base consisted of registry records on 21,000 patients. Out of this 21,000 case load, 13 percent or 2,798 patients were sorted out as being duplicate patient listings. Of these 1,289 cases were updated, while 1,509 were eliminated. This leaves an existing data base of 19,500 patients, a respectable data base for epidemiological studies.

It will now be possible to produce an accurate annual report concerning cancer statistics for the State. The first report was presented at the Annual Meeting of the Delaware Cancer Network's Advisory Board in December. This report covers the years 1972 to 1976 and will include:

1. The ten most frequent cancer sites
2. The staging distribution
3. The primary treatment distribution
4. The age distribution
5. The sex distribution
6. Incidence rate
7. Mortality rate
8. A summary of each year.

The 1977 data for the State will not be available at this time.

A five-year report will also be completed which will include a summary dealing with the data for all five years. This report will be made available to all affiliates of the Delaware Cancer Network.

Plans are also underway to compile a similar report for each of the seven general hospitals in Delaware for the years 1972 to 1977, depicting the cancer situation in each of the hospitals. It will be possible to produce a statistical report for 1977 for all of the hospitals with one exception. The hospital report will include the information contained in the statewide report but on an individualized basis. A five-year hospital report, which will include a summary of the five-year data, will also be compiled. In this way, each of the hospitals will be able to compare its cancer experience with the cancer experience for the State.

Cancer is a reportable disease in Delaware, and I have recently been involved in revising the existing abstract form for all seven hospitals. The revised abstract form will include more detailed information such as previous treatment, specific treatment given, and the causes of death. The treatment data will include the type of surgery, the type of chemotherapy given, amount of radiation given, and other treatment information. This form will result in better statistical

Ms. Ahlschier is Coordinator of the Delaware Cancer Reporting Service.

*An NCI-supported agency located at 1200 Jefferson Street, Wilmington, Delaware 19801. Tel. (302) 428-2113.

data and reporting. The new form and procedure manual will be effective next year.

Mrs. Mary Christie, Cancer Program Consultant with the American College of Surgeons, visited the Delaware Cancer Network on August 9, 1978. She discussed with the Delaware Cancer Network staff the Reporting Service and the revisions which are to take place. Mrs. Christie made some constructive suggestions dealing with the new abstract. These were noted and are included in the revised abstract.

Also included in the Delaware Cancer Reporting Service is the management of the data needs of the Network. Many of the existing programs are to be computerized in order to meet grant and contract reporting requirements more easily. The Network is now using the computer system of the University of Delaware. A terminal is in place in the Network office allowing data to be managed directly.

In many aspects a program is only as good as its data base. With the new abstract and computer revisions, it is possible to have a more accurate and complete Statewide data base system. This system will be able to provide better statistical reporting, thus benefiting the cancer patients, the community, and the State at large.

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President's Page

CHIROPRACTIC SUIT AND THE AMA

At the present time, the AMA is involved in law suits in Pennsylvania, New Jersey, and Chicago over the issue of chiropractic. In only one, the federal court case in Chicago, is the issue of chiropractic as an unscientific discipline the matter before the courts. In Pennsylvania and New Jersey, individual chiropractors are alleging conspiracy in that they have been denied access to laboratory and/or radiology facilities and test results on their patients.

The agreed-upon settlement in the Pennsylvania case states that "Specialists, including those in radiology or clinical pathology, ethically may choose either to accept or decline patients sent to them by chiropractors." Four specialty societies, the American Academy of Orthopedic Surgeons, the American College of Physicians, the American College of Radiology, and the American College of Surgeons were so opposed to the terms of the settlement that they took legal action to try and prevent the finalization of the Pennsylvania case. The specialty societies and other individual physicians feel that the proposed settlement would violate Section 3 of the Principles of Medical Ethics which states, "A physician should practice a method of healing founded on scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle." It is their feeling that acceptance of a referral from a chiropractor constitutes a professional association.

The Judicial Council of the AMA has the authority to interpret the principles of Medical Ethics and has ruled that "The mere acceptance of a patient sent to a physician by another person does not create a 'professional' relationship with that person."

The Principles of Medical Ethics also state that an individual physician may choose whom he will serve. If physicians collectively agree not to accept chiropractic referrals, they will probably be in violation of the Sherman Anti-Trust Act.

At the December Interim meeting of the AMA

the proposed settlement of the Pennsylvania chiropractic suit was brought before the House of Delegates. Doctor Seymour F. Ochsner of New Orleans, speaking for the American Roentgen Ray Society, one of the participants taking legal action against the terms of the Pennsylvania settlement, agreed to withdraw his Society's opposition to the settlement. Doctor Richard Allyn, speaking for the American College of Physicians, agreed to try and seek such a withdrawal of his group's opposition to the settlement.

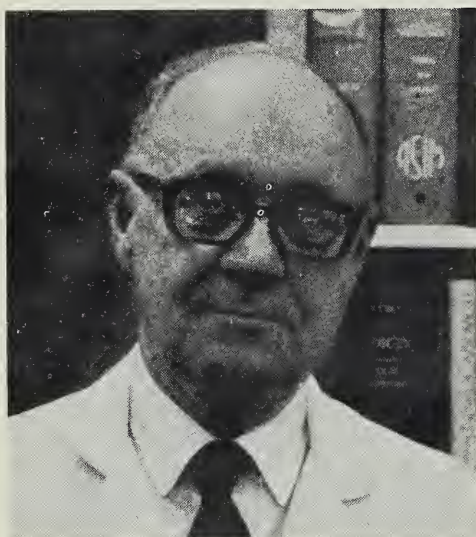
"Physicians should observe all laws" according to Section 4 of the Principles of Medical Ethics and "may choose whom they will serve" (Section 5). The AMA's legal counsel was unable to find a single instance where a radiologist or pathologist was censored or admonished for accepting for treatment or diagnostic services a patient sent by a chiropractor. Nor was counsel able to find a single case where a surgeon was disciplined for performing surgery on a patient referred by a chiropractor. Accepting a referral does not constitute a professional association, and the individual physician has the freedom of choice whether or not to accept this referral (Section 5). The exercise of the right of an individual physician to do this does not constitute a conspiracy against chiropractors nor a violation of the law (Section 4).

The AMA position and the position of the Medical Society of Delaware has not changed with regard to chiropractic. It is still an unscientific cult and nothing in the Pennsylvania settlement changes this. The important suit is the one in Chicago that challenges the basic scientific validity of chiropractic, and it is this suit towards which all efforts must be directed. Only as a united profession can we successfully fight the Chicago suit and the basic issue of chiropractic.



"THE PHYSICIAN IS A DECISION MAKER, AND ALMOST EVERY DECISION HE MAKES COSTS OR SAVES MONEY."

—Dr. William Felts, Past President,
American Society of Internal Medicine



More and more physicians today are beginning to realize the extent of the economic influence they have, and are finding ways of holding costs down.

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What else are physicians doing? Minimizing their patients' hospital stays, whenever possible. Reevaluating routine admissions procedures. Questioning the real need of the diagnostic tests they order for their patients. Avoiding duplicate testing. Trying to discourage their patients' demands for unnecessary medication, treatment or hospitalization. Compiling daily logs of their medical decisions and what they cost. And more.

More physicians today realize what a tough problem we're all faced with. They know this is a challenge for medicine. And that physicians are in the best position to deal with and solve the problem.

*PATIENT CARE Magazine—Outlook 1977, "Face-Off: Cost Containment vs. Chaos," January 1, 1977.

Lyle CB, et al. "Practice habits in a group of eight internists," ANNALS OF INTERNAL MEDICINE 84 (May 1976), 594-601.

Schroeder SA, et al. "Use of laboratory tests and pharmaceuticals: variation among physicians and effect of cost audit on subsequent use," JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 225 (Aug. 20, 1973), 969-73.



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DIABETES AND EVOLUTION: SOME SPECULATIONS

GEORGE F. CAHILL, JR., M.D.

Diabetes mellitus, or now more properly, the diabetes (plural) mellitus, share one common factor, an absolute or relative deficiency in insulin. We must also now add to this definition marked deficiencies in insulin's metabolic effectiveness, because of a few very infrequent disorders of cell receptors for insulin or of insulin's post-receptor activity. These last, as far as we know now, are extreme rarities compared to the usual forms of diabetes. In both the rare disorders and the common forms of diabetes, however, absolute or relative insulin deficiency results in a number of metabolic derangements, of which altered glucose metabolism is the most notorious, both historically and by its ease of measure, especially in the urine.

We now know that there are a number of physiologic alterations which soon follow the abnormal metabolic state of hyperglycemia. These include altered renal hemodynamics and glomerular permeability, altered permeability of peripheral capillaries, and delayed nerve conduction velocity. We also know that after but one to two years of the disease, there is demon-

strably abnormal renal morphology, and fluorescein angiography of the retinal vessels may demonstrate the characteristic abnormalities seen only in diabetics. The rest of the story is too well-known.

One must ask why diabetes occurs in the first place since every physiologic or pathologic process is, in evolutionary terms, on an ascendancy thanks to its selective advantage, or has become superfluous and is in descendancy or even detrimental, sickle cell anemia being the classic for the last-mentioned. Like social classes, pathologic processes are upwardly or downwardly mobile. It has been speculated that the atopic state may have been a selective advantage against parasitic disease, especially of the gastrointestinal tract against helminthic invasion, and we are now left with the price to pay, namely, hay fever and eczema. Could juvenile-onset (Type 1) diabetes be the penalty for the altered immunity, which provided protection against infections or some other processes? There is more and more evidence that a viral insult may initiate autoimmune destruction of one's own pancreatic beta cells, provided there is appropriate genetic susceptibility in the immune make-up; this appears to be inherited in man along with the genes controlling cell surface

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This paper was adapted from his presentation to the 1978 Annual Meeting of the Medical Society of Delaware.

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antigens on chromosome No. 6. Although good comparative epidemiologic data on juvenile diabetes alone are lacking except for some studies in Scandinavia, the United Kingdom, and Michigan and Minnesota, it seems that 1:300 to 1:500 northern European children have diabetes by age 18. It is far rarer in Oriental or black children, although the data are scanty. Was the selective advantage conferred by this altered immune mechanism originally directed against plague, or tuberculosis, or perhaps against rubella or smallpox?

One can also ask why there is an all-or-none effect in the acquisition of juvenile-onset type diabetes? The striking fact that concordance for juvenile-onset diabetes occurs in fewer than one half of identical twins, even though most have lived together in close contact, suggests a threshold phenomenon, all or none. This is also supported by the fact that in my experience as well as that of Dr. Priscilla White, the Joslin Clinic has never seen a permanent remission in a juve-

nile-onset diabetic. Thus once the diabetic trigger is pulled, either the gun fires, or it misfires and doesn't go off at all.

Why is the peak age of onset of juvenile-type diabetes 12-13 years? Throughout life there is a progressive diminution in immunosurveillance. There is a progressive displacement of bone marrow by lymphocytic elements; the thymus atrophies in the second decade. Could any one or all of these waxing and waning processes permit the unique events which initiate beta-cell destruction in a given individual even when he or she lives with a genetically identical twin who is spared? These are topics for future research.

Concerning maturity-onset type diabetes, its prevalence appears high worldwide. Where it is most prevalent (eg, the Polynesians, the blacks, the American Indians) juvenile-onset diabetes is reciprocally diminished. James Neel, the geneticist, has wondered whether maturity-onset type diabetes was some kind of selective advantage in a stuff-or-starve society—in other

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words, a "thrifty" genotype. My own experimental data include some evidence that by decreasing glucose oxidation in peripheral tissues a minimally abnormal glucose tolerance could spare some nitrogen in each feeding-fasting cycle by sparing glucose utilization. Is this enough to explain the current prevalence of the various genes (it is probably polygenic) leading to maturity-onset type diabetes? It is also asked: Since the age of the development of maturity-onset diabetes is usually post-reproductive, how could it have been a selective evolutionary advantage? Mammalian biologists fail to recognize that in a family group, the survival of post-reproductive members is often as important as that of the reproductive or pre-reproductive members, thanks to their accumulated wisdom, child-caring, labor-sharing, and other factors especially if they don't have to be fed very much. Then how does one explain the correlation of maturity-onset type diabetes with obesity and overnutrition? This can at present only be wildly speculated upon, and I have already contributed enough fanciful thought.

Turning now to the complications of diabetes and their pathophysiology, the scientific community is coming more and more to the consensus that the unique abnormalities which occur in the diabetic animal and man result from the dysmetabolism secondary to insulin deficiency. How much is due to the hyperglycemia and how much is due to other events such as altered platelet function, or blood viscosity, or oxygen dissociation, or altered lipids, etc., remain to be dissected. But more and more, the data in man and animal point directly toward hyperglycemia as the major source of the unique diabetic complications.

In Type II or maturity-onset diabetes, the unique anatomic abnormalities which occur in the eye, kidney, and nerve also appear, but other events, especially the accelerated atherosclerosis, are even more prominent, as are other degenerative changes such as senile cataracts and osteoporosis. In the past few years, those interested in aging have shown that in man there is a progressive deterioration of a number of functions with age, especially of renal and pulmonary reserve as well as intellectual capabili-

ties. Eliminating all cancer and heart disease would thus add only a few years to average life survival. The human machine just isn't built to last over ten decades, except for a few individuals, about 15,000 of the over 200,000,000 in the United States who have passed the century mark because they were lucky enough to draw a number of winners, including a better "carburetor," a better "motor," a better "ignition system," better "bearings," etc., from the fetal assembly line. The maturity-onset diabetic may have drawn a poorer quality collection of beta-cells, just the reverse of the centenarian. To use the proper biologic term, he or she inherited an "abiotrophic" insulin-producing mechanism. Yet, according to Neel's and our own as yet flimsy data, at one time it may have been a selective evolutionary advantage to have had this less effective insulin-producing mechanism.

REFERENCE

1. Renold AE, Muller WA, Mintz D, Cahill GF Jr: Diabetes Mellitus in Stanbury JB, Wyngaarden JB, Fredrickson DS (eds): *Metabolic Basis of Inherited Disease*, pp 80-109. New York, McGraw-Hill, 1978.

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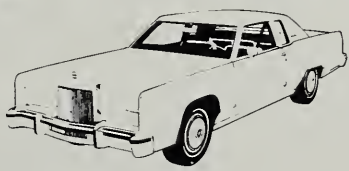
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TWIN PREGNANCY IN A SEPTATE UTERUS

THEODORE G. ZALESKI, M.D.

HOWARD GILLIS, II, M.D.

Introduction

Congenital abnormalities of the female reproductive tract have always been a topic of interest among obstetricians and gynecologists. Aside from the academic interest, these anomalies may contribute to unusual and difficult obstetrical problems when associated with pregnancy. The frequency with which patients with malformations of the uterus are identified during pregnancy is not clearly established but has been variously reported to occur in 0.13 to 3.3 percent of pregnancies.¹⁻⁵ Septate uterus accounts for only 4-5 percent of all reported uterine abnormalities associated with pregnancy.

While twin pregnancies in congenitally anomalous uteri are not uncommon,⁶⁻⁸ twin gestations progressing to fetal viability occur very infrequently in patients with septate uteri,^{1,5,9,10} (Table 1) and the completely septate uterus has been rarely reported to be associated with twin pregnancy.¹⁻⁴

Case Report

The patient was a 35-year old white married gravida 6 with only one living child referred to the Milton S. Hershey Medical Center of the Pennsylvania State University at 30 weeks' gestation, 24 hours following spontaneous rupture of the membranes.

The patient's first pregnancy was delivered at 32 week's gestation following premature rupture of the membranes and a 12-hour labor. This three-pound, eight-ounce infant survived. Her next three pregnancies resulted in spontaneous first trimester abortions. Her fifth pregnancy resulted in a stillborn infant at 28 weeks' gestation after a ten-hour labor.

Dr. Zaleski is an Assistant Instructor in the George Washington University Medical School. He was a resident in Obstetrics-Gynecology at the Wilmington Medical Center at the time this paper was written.

Dr. Gillis is the Consultant in Gynecology for the United States Air Force in Suffolk, England.

The current pregnancy was uncomplicated until three months' gestation when she had light vaginal spotting; medroxyprogesterone acetate was prescribed. At 28 weeks' gestation an abdominal x-ray revealed a twin pregnancy. (Figure 1) Shirodkar circlage was performed at this time because of premature cervical dilatation. Ten days following the circlage, spontaneous premature rupture of the membranes occurred. The patient was admitted to her local hospital where the Shirodkar suture was removed. Pelvic examination then revealed the cervix to be two centimeters dilated and 75 percent effaced. She was not in labor. Prior to transfer to the Milton S. Hershey Medical Center, she was given 200 mg Solu-Cortef (*Upjohn*) and one gram of ampicillin.

At the time of admission physical examination and vital signs were normal. The uterine fundus was palpated three centimeters above the umbilicus; pelvic examination was unchanged from the previous day. Each fetus was estimated to weigh 1200 grams. Continuous external monitoring revealed irregular mild contractions with normal fetal heart rates. Laboratory studies revealed a white blood count of 11,700 with 93 percent polymorphonuclear leukocytes, hematocrit of 28%, and blood type O Rh positive. The patient was put at bedrest and given 12 mg beta methasone intramuscularly.

Twelve hours later spontaneous labor began. Ten hours later, at the termination of the first stage, the patient's temperature rose to 37.9°C. Twenty million units of aqueous penicillin were administered intravenously and the patient transferred to the delivery room. Uterine contractions at this time were both weak and irregular, and her expulsive efforts were ineffective. With twin A vertex at +2 station, delivery by vacuum extraction was performed under pudendal block

TABLE 1
TWIN GESTATIONS IN PATIENTS WITH SEPTATE UTERI

Author	Date	Method of Delivery	Time of Diagnosis of Septate Uterus	Complications of Pregnancy and Delivery	Fetal Outcome
Kickham	1922	Cesarean section	At delivery	Eclampsia with maternal death	6 lb. 6 lb. 14 oz.
Rauch	1938	Vaginal	At delivery	Premature labor, retained placenta, puerperal hysterectomy	4 lb. 4 lb.
Fenton Singh	1952	No record	No record	No record	No record
Miller	1961	Cesarean section	At time of previous delivery	Pre eclampsia	—
Gillis Zaleski	1975	Vaginal	At delivery	Premature rupture of membranes, premature labor	1400 grams 1300 grams

with nitrous oxide analgesia. A 1400 gram, male infant with Apgar 8 was delivered without difficulty. Manual exploration revealed the uterus to be completely septate with a single fully dilated cervix. Twin B could be felt in the left



FIGURE 1

Flat plate of abdomen showing twin gestation. Parallel lie of fetuses and lack of overlap of fetal parts suggest presence of uterine anomaly.

cavity through a five centimeter opening with the septum partially obstructing the cervix. Again using vacuum extraction, twin B was delivered as a vertex. Intermittent traction was required for about five minutes to overcome resistance from the septum, after which delivery was uncomplicated. The second twin was an Apgar 8 male infant weighing 1300 grams. Two completely separate placentas were then manually delivered, one from each cavity. Careful palpation revealed a smooth external uterine contour without external evidence of the anomaly.

Antibiotics were continued for the duration of the patient's postpartum course, which was otherwise uncomplicated. She was discharged on her fifth postpartum day. Cultures of the amniotic fluid grew *Bacteroides* species and anaerobic gram positive cocci.

Her infants also did well. They evidenced no signs of respiratory distress syndrome and were discharged at about three weeks of age.

Discussion

Uterine malformations have long been associated with reproductive difficulties. The main hazards of pregnancy and labor in patients with a double uterus arise from a growing fetus in a restricted environment. Included among these complications are: abortion and premature labor, antepartum hemorrhage, abnormal presentation, dysfunctional labor, placental insufficiency, and faulty separation of the placenta leading to third-

stage complications.¹¹⁻¹⁴ In patients with uterine malformation the incidence of spontaneous abortion may be as high as 25 to 53 percent.¹⁵⁻¹⁷

Schauffler states that uterine septa and poorly vascularized areas of the fundus are responsible for this high incidence.¹⁵ Jones and Wheelless have suggested that of the various types of uterine malformation, the septate uterus is most likely to cause severe reproductive difficulty.¹⁸ They reported on 22 patients with recurrent abortion in whom no etiology other than double uterus could be implicated; in 21 of their 22 patients the uterus was septate.

It is emphasized by many authors that a hystrogram must be part of the evaluation of every patient with recurrent unexplained pregnancy loss. Our patient had three consecutive first trimester abortions and might fall in this category. While the typical patient will present with fetal wastage early in pregnancy, some patients, like ours, will have premature labor in the third trimester. Halbert and Loughhead suggest that the uterus which is derived from a single müllerian duct instead of fusion of two ducts may have an impaired ability to accommodate a term-sized pregnancy.¹⁹ This could also be true of the septate uterus, each cavity being derived from a single müllerian anlage. Halbert also commented on the high incidence of premature rupture of the membranes in uterus didelphys (double uterus). In our limited experience this seems to occur frequently in the septate uterus as well; however, since our experience has been at a referral center, it is possible that selection effects are responsible for this apparent high incidence.

Dysfunctional labor and third stage complications may occur secondary to faulty uterine musculature.¹⁶⁻²¹ In our patient there was prolongation of the first stage with generally poor uterine contractions throughout labor. The fact that surgical delivery was required is not at all unusual; Findley reported only 38 percent spontaneous deliveries in his series of pregnant patients with double uteri.²¹ Similarly, manual removal of the placenta is frequently required because of failure of spontaneous separation. This may be due to irregularities of contour, insertion of the placenta on the septum, or faulty

contraction. Postpartum hemorrhage is said to occur in about 20 percent of patients.

Intrapartum diagnosis of septate uterus is extremely difficult. Jones emphasizes that the diagnosis is often missed on pelvic examination and is later made at the time of manual removal of the placenta, curettage, or laparotomy.¹⁷ The presence of lower tract duplication suggests a possible failure of fusion at other sites also. In our patient the twin gestation provided a rather unique diagnostic clue which was overlooked. The A-P x-ray of the pregnant abdomen showed no overlap of fetal parts from the two fetuses. The persistent parallel lie of these two infants could, in retrospect, have suggested the diagnosis, especially in view of the additional history of pregnancy loss.

Summary

A patient with twin pregnancy and septate uterus which resulted in two living children has been presented. Her obstetrical history included three previous first-trimester abortions.

Uterine malformation should be suspected in

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all cases of recurrent pregnancy loss in any trimester. Pelvic examination may suggest the diagnosis, and it may be confirmed by hystero-gram, dilatation and curettage, manual exploration of the uterus after delivery, or at the time of laparotomy.

Previously reported complications of pregnancy with associated uterine anomalies include recurrent abortion, antepartum hemorrhage, premature labor, dysfunctional labor, placenta dysfunction, abnormal fetal presentation, retained placenta, and postpartum hemorrhage. Of all the uterine anomalies septate uterus is the one most frequently associated with reproductive difficulties. The septate uterus represents 4-5 percent of uterine malformations seen in association with pregnancy.

REFERENCES

1. Fenton A, Singh BP: Pregnancy associated with congenital abnormalities of the female reproductive tract. *Amer J Obstet Gynecol* 63:745, 1952.
2. Baker WS, Roy RL, Bancroft CE, et al: Congenital anomalies associated with pregnancy: An analysis of 118 cases. *Amer J Obstet Gynecol* 66:580, 1953.
3. Philpott NW, Ross JE: Congenital uterine anomalies and associated complications of pregnancy. *Amer J Obstet Gynecol* 68:285, 1954.
4. Blair RG: Pregnancy associated with congenital malformations of the reproductive tract. *J Obstet Gynecol Br Commonw* 67:36, 1960.
5. Greiss FC, Mauzy CH: Genital anomalies in women. *Amer J Obstet Gynecol* 82:330, 1961.
6. Williams B, Cummings G: An unusual case of twins. *J Obstet Gynecol Br Emp* 60:319, 1957.
7. Brown DB: A case of uterus pseudodidelphys and twin pregnancy. *J Obstet Gynecol Br Emp* 63:395, 1957.
8. Varten OK: Uterus didelphys with double pregnancy. *J Obstet Gynecol Br Emp* 65:120, 1958.
9. Rauch E: Multiple pregnancy in a septate uterus with retained adherent placenta. *Amer J Obstet Gynecol* 36:1069, 1938.
10. Miller MC: Twin pregnancy in a septate uterus. *Obstet Gynecol Br Commonw* 68:673, 1961.
11. Falls FH: A study of pregnancy and parturition in primiparae with bicornuate uteri. *Amer J Obstet Gynecol* 15:399, 1928.
12. Puddicombe JF: Some uterine anomalies due to variation in the fusion of the müllerian ducts. *Surg Gynecol Obstet* 49:799, 1929.
13. Jarcho J: Malformation of the uterus. *Amr J Surg* 71:106, 1946.
14. Hunter W: Pregnancy in the deformed uterus. *J Obstet Gynecol Br Emp* 64:243, 1957.
15. Schaffler GC: Double uterus with pregnancy. *JAMA* 117:1516, 1941.
16. Smith FR: The significance of incomplete fusion of the müllerian ducts in pregnancy and parturition with a report of 35 cases. *Amer J Obstet Gynecol* 22:714, 1931.
17. Jones HW Jr, Delfs E, Jones GES: Reproductive difficulty in double uterus. *Amer J Obstet Gynecol* 72:865, 1956.
18. Jones HW Jr, Wheelless CR: Salvage of the reproductive potential of women with anomalous development of the müllerian ducts: 1868-1968-2068. *Amer J Obstet Gynecol* 104:348, 1969.
19. Halbert DR, Loughhead JR Jr: Uterus didelphys: Two patients with pregnancy alternative in each hemiuterus. *J Reprod Biol* 6:571, 1968.
20. Taylor HC: Pregnancy and the double uterus. *Amer J Obstet Gynecol* 46:388, 1943.
21. Findley P: Pregnancy in uterus didelphys. *Amer J Obstet Gynecol* 72:318, 1926.

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Letters to the Editor

To the Editor:

There is much ferment in our community whether physicians should join the proposals, still in the planning stage, of DuPont Company and/or Blue Cross-Blue Shield of Delaware for an Individual Practice Association Health Maintenance Organization (IPA HMO).

At this time no detailed specific plans have been completed, but discussions are being carried on with the leadership of the medical community.

The case for or against such plans is not clear cut. Those who back the plans maintain that, while allowing each physician to continue seeing patients in his usual professional manner in his own office on a fee-for-service basis, they yet make it possible for the group of physicians to offer to those patients who elect membership with them total prepaid care for a predictable monthly fee with strong emphasis on preventive care and early sickness care. They do this, they say, by financial savings from reduced hospital days.

Those who oppose these plans maintain that they produce savings by limitation of needed care and denial of required hospital admissions.

IPA HMO's have been set up in many places in our country. Some have succeeded brilliantly, some have failed miserably.

Whether or not such a plan will succeed in Delaware by giving to patients all the advantages of prepaid care while still preserving totally the physician-patient relationship, we do not know.

Those of us who believe in freedom of choice and pluralism in health care delivery believe that a decent respect for the opinion of the individual physician members of the medical societies requires that whenever DuPont Company and Blue Cross-Blue Shield have their finished

plans ready that the Boards of Directors of New Castle County Medical Society and Medical Society of Delaware submit those plans in writing to their members for their individual consideration.

Participation must be only by those patients or groups of patients who elect such care and by those physicians who freely make such a choice.

After a trial of one year, a careful medical audit will show whether or not health care has been delivered more effectively while financial costs have been restrained.

Then and only then can a valid judgment be made.

DAVID PLATT, M.D.

❖ ❖ ❖

To the Editor:

I was particularly interested in the editorial in the October *Delaware Medical Journal* entitled *Manners in the National Health Arena*. As a physician, I was embarrassed merely by reading about the behavior of your physician colleagues when a toast to the President of the United States was proposed. It is depressing to think that many of these physicians who displayed such rudeness and lack of fundamental courtesy are probably considered leaders in our profession. I for one would like to disassociate myself with any such group of physicians and am loath to have them considered my representatives.

If you think it would be of any benefit, or have any effect on their future behavior, I would be only too glad to express my sentiments to the President of the American Medical Association.

ARTHUR F. ZIMMERMAN, M.D.

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As a physician, you have the right to prescribe the drug which you believe will most benefit your patients. Now, substitution laws make it more difficult to exercise that right. In many states, unless you specifically direct pharmacists to dispense your brand-name prescription as written, they may be required by law to substitute another drug for your brand-name prescription.

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PROCEEDINGS OF THE HOUSE OF DELEGATES, 1978

MEDICAL SOCIETY OF DELAWARE

The 189th Annual Meeting of the House of Delegates, Medical Society of Delaware, was called to order at the Delaware Academy of Medicine, Wilmington, Delaware, on Friday, September 22, 1978, at 1:30 p.m., John J. Egan, M.D., President, presiding.

A quorum was declared.

A motion was made, seconded, and approved to accept the minutes of the 1977 Session.

(All reports were accepted as published unless otherwise noted.)

REPORTS OF THE OFFICERS

REPORT OF THE PRESIDENT

Actions taken by the Society during this year are outlined in the report of the Board of Trustees. The Society and the President are indebted to the individual members of this Board for their dedicated service throughout the year. Each Trustee has been an active, contributing party to the thoughtful and timely deliberations of the Board at its monthly meetings.

Once again this year the Board authorized a restraint on the rate of rise of the weighted aggregate average of the 90th percentile fees for each specialty. Exercise of this restraint has been interpreted by the public as a responsible action demonstrating our concern over the accelerating rise in medical care costs in this community. Even more important, in my view, this action by the Board and its acceptance by the membership of the Society demonstrate that at last we each recognize that we share the responsibility for one another's fees.

It is now time to update our filed fees for the coming year. Each fee should be thoughtfully reconsidered. The fee filed for each procedure should compensate us at a level we deem necessary to permit us to offer the service with our maximum effort. Fees filed in this spirit will almost automatically be ac-

ceptable. Fees filed in excess of this or in a spirit of "beating the system" are self-defeating. Fees filed by individuals acting in concert with others of their specialty are also contrary to the very thesis of our contract. From the experience I have had this past year I urge each member to review his schedule of fees and file a schedule for which he is ready to stand accountable, both to his peers and his patients. If we each file in this fashion, there will be no need for the Board to negotiate any formula of restraint.

A second matter of concern this year was Certificate-of-Need legislation which would have included certain physicians' offices. Our testimony before the planning agencies to exclude all physicians' offices from this legislation was unsuccessful. We were forced to turn to the political process to seek relief. For the present we have been successful, but this will probably be short-lived. This experience teaches us two things. First of all, we must seek effective input to the planning agencies despite the fact that we have only token representation. It seems absurd that the currently mandated health-planning process provides the medical profession no larger voice than any other health professional or so-called health provider. The second lesson this must teach us is that we can no longer afford to stand apart from the political arena. Individually and through our political action committee we must secure the attention and response of our political representatives through tangible support of those who share our views or will give them an honest hearing.

The third matter which I would like to review in this report is the subject of health care cost control as raised by the duPont Company. In October 1977 representatives from the duPont Company met with officers of our Societies to point out that they were undertaking a study aimed at controlling the rate of rise of their costs in employee hospital-medical surgical programs. Our position as expressed to them at that time was that we would be deeply interested in being kept abreast of their analysis of the problem, cooperative with them in their efforts and more than willing to participate in cost control measures that

would not compromise patient care nor compromise the legitimate interests of the medical profession. They later advised us of their feasibility studies concerning health maintenance organizations. Their feasibility studies concerning both closed panel and open panel HMO's continue and should be completed shortly. We are not yet privy to the results of these studies. The Board's opposition to the concept of an HMO has been conveyed to the representatives of the duPont Company. Additionally, numerous individuals and certain specialty groups have communicated to the duPont Company representatives that a sizeable majority of the profession are opposed. In recent meetings with duPont Company representatives your Society officers have taken a stance whereby we would hope the Company and the Society can study the problem locally and secure reasonable control of cost escalation without the risks inherent in the HMO concept.

The Board of Trustees and the officers of the Society have worked diligently to properly represent the membership. To do this effectively we require untold hours of help from our State Society staff. As the final item in this report I would like to commend our staff, both individually and collectively. They compare favorably with any staff organization that I have encountered in my travels this year. They are efficient, effective, and unswervingly loyal. I hope that each member of the Society will personally take the time to express his acknowledgement of and appreciation for their splendid service.

JOHN J. EGAN, M.D.
President

REPORT OF THE PRESIDENT-ELECT

During the past year, it has been an honor and pleasure to serve as President-Elect of the Medical Society of Delaware and to work with Doctor John Egan. Doctor Egan has been most helpful in keeping me informed of Society affairs during the past year; and, with Doctor Egan and Anne Shane Bader, the Executive Director, I have been actively involved with the Medical Society over the past year. At the Board of Trustees level and committee level, there was involvement with several important matters and the highlights are as follows:

1. The Medical Society of Delaware in cooperation with the Association of Delaware Hospitals, has set up a committee to implement the Voluntary Effort to contain hospital costs. Doctor C. Papastavros and I have been involved with this, along with representatives of the Association of Delaware Hospitals. Both nationally and locally, the rate of increase in U.S. hospital expenditures has been curbed, and efforts are continuing in this area.
2. Certificate-of-Need legislation was passed by the Delaware Senate and House of Representatives

and was signed by the Governor. Through the efforts of the Medical Society, we were able to exclude all physicians from this legislation and were able to keep the legislation within the federal guidelines.

3. The Health Systems Agency in Delaware is now involved in establishing a Statewide Health Plan with various Task Forces assigned to offer proposals and goals for this Health Plan. The Medical Society will be closely monitoring these meetings, and physician input is needed and is being given at the Task Force level.
4. The by-laws of the Medical Society have been in need of revision, and a committee chaired by Doctor C. E. Graybeal has been actively working on these revisions.
5. The American Medical Association sponsored a six-day seminar on the National Health Insurance Program in Great Britain. During this excellent seminar, the problems and failures as well as some of the successes of the National Health Service were discussed, and one was able to observe on a first-hand basis the working of the British system.

I look forward to my year as President, and I will continue to rely on the advice and counsel of Doctor Egan as well as the Board of Trustees and the members of the Medical Society.

ANTHONY L. CUCUZZELLA, M.D.
President-Elect

REPORT OF THE VICE PRESIDENT

It was an honor for me to serve as the vice president this past year.

I am thankful that my prayers were heard and our president was able to finish his term in good health and spirit.

It is hard to understand the load of work that the president has to carry these days.

One may think that because of the small size of our Society there would not be any significant amount of work; however, a small society has as many problems as a large one and none of the advantages of a big society which can afford more staff and more people to tap for specific projects.

The problems that face our profession are numerous, varied, and overwhelming. The fact that the president has to carry a full load of his practice, if he wants to eat and pay his bills, in addition to the Society's work, makes him almost a superman. At some point, the Society will have to think seriously about compensating, at least partially, the president, so that he may be able to devote adequate time to the affairs of the Society.

We are blessed with an extremely competent, tire-

less, and selfless staff. It is the backbone of the Society; nevertheless, it can advise and make decisions up to a point. The final responsibility lies with the elected officers and mostly with the president. If he is to make the right decisions, he has to be informed, which means he has to go through an inordinate amount of material, which is time-consuming. At some point, we will have to help our president either through compensation or some other form of help to be able to cope with the ever-increasing load of work, primarily because of the intrusion of third parties and government into the practice of medicine.

CHRISTOS S. PAPASTAVROS, M.D.
Vice President

REPORT OF THE SECRETARY

There were two hundred twenty meetings held this year including today's meeting. Ten meetings were devoted to the transaction of business matters by the Board of Trustees. The Society office made preparations for two hundred ten meetings.

There were two seminars in November: *Violence in the Family* and *Medico-Legal Aspects of Office Practice*. *The Art of Negotiating for the Medical Profession* was held in February. The Medical Society of Delaware promoted June as "Self-Health" month through bill-boards, bumper stickers, and radio publicity. All business transacted by the Society has been recorded in the minutes as presented by the Secretary.

1978

	Dues-Paying Members	Dues-Exempt Members	Total
Kent	60	10	70
New Castle	506	76	582
Sussex	90	14	104
	656	100	756

1977

	Dues-Paying Members	Dues-Exempt Members	Total
Kent	58	11	69
New Castle	466	75	541
Sussex	85	14	99
	609	100	709

The Society has had one hundred ten inquiries from physicians seeking placement in Delaware. The office has corresponded with these persons and acted as liaison between them and local physicians seeking associates. Complimentary ads have been placed in the *Delaware Medical Journal* for doctors seeking local opportunities. The office requests that physicians seeking associates so inform it.

JOSEPH E. BELGRADE, M.D.
Secretary

REPORT OF THE TREASURER

September 1978 finds this Society in the best financial shape it has ever experienced. We have a Treasury surplus of \$25,000, a 71% increase in the value of the Society's stock portfolio in the past four years, a significant Medical Defense Fund and a growing Medical Benevolence Fund.

Funds authorized by the House of Delegates and administered via savings accounts and treasury bonds are as follows as of September 1, 1978. (1) Medical Defense Fund—\$8,291.38. (2) Medical Education Fund—\$8,102.18. (3) Medical Benevolence Fund—\$2,575.55.

The Treasury surplus reflects the much appreciated assistance of the Board of Trustees and the stringent expenditure control and increased revenues due to rising interest rates as well as increased Society membership.

The Treasurer suggests the commendation of the House of Delegates to Mr. Richard West of Brittingham Associates who has shepherded our stock portfolio without expense to the Society to a substantial increase of 71% and to Doctor Ignatius Tikellis for his assistance in negotiating fee expense returns and the substantial increase in Society membership both of which aided our financial picture.

PETER R. COGGINS, M.D.
Treasurer

(This report was filed.)

MEDICAL SOCIETY OF DELAWARE INTERIM TREASURER'S REPORT

September 5, 1978

BALANCE

December 31, 1977

Delaware Trust Company \$ 637.95

RECEIPTS

Dues \$122,368.00

Negotiating

Workshop 450.00

Addressograph 171.11

Miscellaneous 142.75

Interest and

Investments 12,580.27

TOTAL RECEIPTS \$ 135,712.13

Transfer for Interest \$ 71,000.00

Reimbursed 4,751.59

DISBURSEMENTS

Office Personnel

Employee Benefits \$ 4,232.42

Salaries 43,625.17

Employer Tax 2,925.71

Office Operation

Contribution to

Academy \$ 4,370.00

Printing, Postage, Telephone, Supplies,	
Stationery	13,239.75
Service Contracts/	
Xerox	3,928.65
Storage	108.00
Audit	1,400.00
Kelly Services	728.31
Travel	
AMA Delegate and	
Contingency	\$ 3,017.46
Committees and	
Contingency	4,021.02
Subscription/Dues	680.91
Contributions	785.00
Public Relations—Ned	
Davis Associates ..	6,543.00
Legal Counsel	1,598.15
TOTAL DISBURSEMENTS	\$ 91,203.53
Transfer for Interest	110,176.34
Reimbursable	2,630.04

RESTRICTED FUNDS

RECEIPTS

AMA Dues	\$ 98,585.00
Delaware Medical	
Journal	6,510.00
Kent County	1,210.00
Sussex County	835.00
DELPAC	1,590.00
Blood Bank	697.00
Annual Meeting—	
grants	1,300.00
exhibits	4,750.00
meals	1,751.50
Other grants	335.00
Education Fund	3,255.00
Medical Defense	
Fund	651.00
Medical Benevolence	
Fund	651.00
AMA Rebate	910.63
TOTAL RECEIPTS	\$ 123,031.13

DISBURSEMENTS

AMA Dues	\$ 98,500.00
Delaware Medical	
Journal	6,440.00
DELPAC	1,500.00
Annual Meeting	319.00
Education Fund	3,253.00
Medical Defense	
Fund	6,447.00
Medical Benevolence	
Fund	651.00
TOTAL DISBURSEMENTS	\$ 117,110.00

BALANCE

Delaware Trust Company	
September 5, 1978	\$ 14,012.89

PETER R. COGGINS, M.D.
Treasurer

(See related charts on page 677.)

REPORT OF THE BOARD OF TRUSTEES

The Board of Trustees has met monthly since the 1977 House of Delegates with the exception of July. Many items of continuing interest such as HMO's, Nurse Practitioners, Certificate of Need, Health Planning, and Blue Shield's discrimination against non-participating physicians in the vision and hearing program consumed an extraordinary amount of time.

Throughout the year the President, Vice- President, and the President-Elect have acted as a reference committee to the Board of Trustees in reviewing the committee reports and have formulated a recommendation for each one. This has speeded up the work of the Board.

Annual meeting dates for 1979 through 1982 were approved as follows:

November 16-17	1979
November 14-15	1980
September 18-19	1981
October 15-16	1982

The Board of Trustees considered an invitation for the Society to participate in Governor's Health Week. This was considered favorably by the Board and was carried out by the staff and auxiliary members.

Through Board action the Medical Society of Delaware presented a Seminar on Negotiating February 11-12, 1978.

A resolution that the House of Delegates passed in 1977 was carried out by the President when he appointed a Committee to Monitor Health Planning in Delaware. The staff has been extremely active in this area as they have been in attendance at virtually all meetings in order to help keep physicians abreast of what planning is being done.

The Board received a briefing from Anthony L. Cucuzzella, M.D., President-Elect, on the working of the Steering Committee on a Voluntary Effort in Cost Containment of which he is a member. The Committee is a response to a joint national effort to contain costs by the American Medical Association, the American Hospital Association, and the American Federation of Hospitals.

B. Wilson Redfearn, Esquire, was selected as the Society's attorney.

The rebate from Aetna is substantial, and the stability of the 1979 liability insurance fees was noted by the Board.

The Board was pleased to note that the Legislature passed Certificate of Need legislation excluding all physicians from the law.

Consideration was given to beginning Board meetings an hour or an hour and a half earlier with no decision being made.

ANNE SHANE BADER
Executive Director

PERFORMANCE MONITOR

MEDICAL SOCIETY OF DELAWARE

Date	Dow Jones Industrial Average	Period Change	Cumulative Change	Unit Value	Period Change	Cumulative %Change
8-28-74	666.61	—	—	9.96	—	—
12-31-74	616.24	(7.6)	(7.6)	9.93	(.3)	(.3)
3-31-75	768.15	24.7	15.2	13.00	30.9	30.5
6-30-75	878.99	14.4	31.9	15.00	18.5	54.6
9-30-75	793.88	(9.7)	19.1	12.99	(15.6)	30.4
12-31-75	852.41	7.4	27.9	13.46	3.6	35.1
3-31-76	999.45	17.2	49.9	14.65	8.8	47.1
6-30-76	1,002.79	.3	50.4	14.47	(1.2)	45.3
9-30-76	990.19	(1.3)	48.5	14.39	(.6)	44.5
12-31-76	1,004.65	1.5	50.7	14.60	1.5	46.6
3-31-77	919.13	(8.5)	37.9	14.62	.1	46.8
6-30-77	916.30	.3	37.5	15.86	8.5	59.2
9-30-77	847.11	(7.6)	27.1	16.34	3.0	64.1
12-30-77	831.17	(1.9)	24.7	16.26	(.5)	63.3
3-31-78	757.36	(8.9)	13.6	15.99	(1.7)	60.5
6-30-78	818.95	8.1	22.9	17.06	6.7	71.3

MEDICAL SOCIETY OF DELAWARE STOCK PORTFOLIO

JUNE 30, 1978

Quan.	Security	Cost	Unit Cost	Mkt. Price	Cost/Price Index	Market Value	Income Rate	Total Income	Yield on Market	Percent Portfolio
200	Chromalloy American	4,346.89	21.73	20 ³ / ₈	93.7	4,075.00	1.00	200	5.0	9.2
700	Transcontinental Oil	4,344.90	6.21	6 ⁷ / ₈	111	4,812.50	—	—	—	10.9
200	Houston Industries	6,791.59	33.96	30 ³ / ₈	89.5	6,075.00	2.12	424	7.1	13.8
300	Four Phase Systems	5,477.60	18.26	29 ³ / ₈	100	8,812.50	—	—	—	20.0
1100	General Housewares	5,124.40	4.66	4	86	4,400.00	—	—	—	10.0
200	Diamond Shamrock	5,811.25	29.06	25 ¹ / ₂	88	5,100.00	1.40	280	5.5	11.6
300	Tiger Intl.	6,627.42	22.09	24 ⁷ / ₈	113	7,462.50	.60	180	2.4	16.9
200	Scott Paper	3,461.34	17.31	16 ³ / ₄	97	3,350.00	.76	152	4.5	7.6
		41,985.39				44,087.50		1236		
Cash		7.44				7.44				
Total Portfolio		41,992.83				44,094.94		1236	2.8	100.0

UNITS — 2,584

UNIT VALUE — \$17.06

REPORT OF THE AMA DELEGATE

1977 INTERIM CONVENTION

The AMA meeting of 1977 was the first referred to as the interim meeting and was held in Chicago. Doctor Roger Thomas, Jr. and I were the only persons present from Delaware. Roger is going to make a very excellent delegate. He quickly caught on, and we split up our assignments and attended as many of the various reference committee meetings as possible.

Reference Committee on Amendments to the Constitution and Bylaws

As far as it's possible, I believe one line reports are the only way that I can tell of the accomplishments or changes in the constitution and bylaws.

1. A change in bylaws was suggested to be considered at the Annual Meeting. This change would permit residents in the military service to be represented at the AMA-RPS Assembly.
2. Henceforth, as a result of the meeting, selection

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sites for the meetings of the House of Delegates will be the responsibility of the Board of Trustees.

3. The Scientific Program held as part of the AMA Annual Convention will be discontinued after the 1978 Annual Convention.
4. The Council on Continuing Education will be charged with developing and expanding cooperation with national specialty organizations and with advising the Board of Trustees regarding sites for the Winter Scientific Meeting and Regional Postgraduate Meetings.
5. By decision of the House of Delegates there will be no change in the present structure of the AMA presidency or the chief executive's office.

These were the salient points of the Committee on Constitution and Bylaws.

Reference Committee A

(Deals with Insurance and Medical Service)

1. Confidentiality of Computerized Patient Information

It was accepted that a physician should respect the patient's expectations of confidentiality concerning his records, but that the physician should also respect the patient's authorization to provide information from the medical record to those whom the patient authorizes to inspect all or part of it for legitimate purposes.

2. The Association will continue its activities with the public and HEW in asking for discontinuance of release of Medicaid and Medicare reimbursement lists.
3. Medicare Fee Profiles

The AMA went on record with the following recommendations:

- a. That physicians bill for services to Medicare patients at their current reasonable charge level for all patients.
 - b. That the Association's policy concerning delineation of physicians' fees by geographic area be reaffirmed.
 - c. That the Association continue to seek elimination of the economic index as a limit on Medicare reimbursement and seek more frequent updating of physician profiles for all physicians.
 - d. That in view of the special problems of rural areas, the Association also seek elimination of the economic index and seek more frequent updating of physician profiles in medically underserved areas, emphasizing that this should not be taken as implying acceptance of the index in present time lag for other areas.
 - e. That the Association continue through all appropriate channels of communication to inform physicians as to the methods by which physician fees profile are established by Medicare. Item 4, Report R, of the Council on Medical Service is to be given wide distribution, and the Council on Medical Service is asked to continue its exploration of ways to simplify certification and recertification procedures under the federal programs.
4. Abortion (Resolution 3)
This is important because it is a problem which we have been struggling with here in our state, and it has been referred to the Board of Trustees for further in-depth study. I would recommend that our Board of Trustees look at Resolution 3 and come up with appropriate statements to the AMA as to their wishes.
Resolution 3 states: "That the AMA advise the United States Congress, the Department of Health, Education and Welfare, and all other applicable third party payors, that elective abortion services rendered under Medicaid and in other third party payment programs should be recognized as compensable services."
 5. Medicaid Provider Agreements (Resolution 7)
It would be helpful if our Board of Trustees would again supply the AMA Board of Trustees with information from our state on Resolution 7 which concerns itself with Medicaid provider agreements.

Resolution 7 asks the AMA to inform its members of the effect that the Medicaid "Provider Agreement" may have on their practice, and to develop and have introduced in Congress legislation that would remove the use of a "Provider

Agreement" as a requirement for participation under Medicaid.

6. Community Health Centers

This resolution asking that the AMA start a feasibility study in examining and evaluating the effectiveness of community health centers and report back to the House of Delegates was adopted.

7. Peer Review of Non-Members

A report encouraging medical societies to conduct peer review of physicians practicing within their jurisdictions regardless of medical society membership was adopted.

8. Current Procedural Terminology

Resolution 66 which encourages use of CPT and asks that it be recognized and utilized by all physicians, governmental and third party payors was adopted.

9. Third Party Carrier Discrimination Against "Non-Participating" Physicians

Resolution 64 passed with this resolve: That the American Medical Association oppose third party differentiation between covered services provided by participating and non-participating physicians as discriminatory against the physician who does not have a separate contractual relationship with the carrier and inhibiting the patient's free choice of physicians and be it further Resolved that this position be communicated to all health insurance carriers throughout the Health Insurance Association of America.

10. Inappropriate Restrictions on the Use of Medical Assistants

Resolution 15 was adopted in an amended form and states: Resolved, that provisions in state legislation which prohibit the performance by allied health personnel working as assistants to and under the direction, control and responsibility of the physician of acts the delegation of which is consistent with good medical practice improperly restricts the ability of the physician to use effectively such personnel in patient care; and be it further Resolved, that the AMA urge the constituent state medical societies to oppose vigorously and resolutely any legislation containing such improper restrictions and to support legislation to remove such restrictions where they exist.

Reference Committee B
(Deals with Legislation)

1. Fiscal Responsibility for State Legislation

This refers to a model bill which can be provided to all state legislators which would propose fiscal notes on all bills before any public hearings can be held or vote taken and which would provide a reliable estimate of the dollar effect that the proposed legislation would have on local and state governments and on the private sector.

2. Extension of Certificate of Need to Physicians' Offices

This was a resolution concerning itself with the extension of certificate of need to physicians' offices. The resolution was passed: Resolved, that the AMA be prepared to join with a state medical society, at the request of the society, that commences an appropriate legal action challenging a state certificate of need law that includes physicians' offices in that state.

3. Federal Requirements for VA Hospitals and HMO's

The following resolution was passed: That the AMA have introduced and strongly support the passage of legislation to place all governmental institutions, whether state, county, municipal, except for Department of Defense institutions and federal, under the same health planning, PSRO, and other federally mandated health care requirements which are imposed upon private institutions by federal law.

4. Opposition to National Guidelines for Health Planning

The House adopted a resolution in opposition to the national guidelines for health planning: Resolved, that the AMA strongly oppose the content of the national guidelines of health planning as published in the *Federal Register* of September 23, 1977 as arbitrary and insensitive to local needs and that the AMA also strongly oppose the manner in which these standards were compiled and promulgated and be it further Resolved, that the AMA inform all other members of the federation of medicine of the AMA's position.

5. Withdrawal of Support for Federal Programs

The AMA went on record that it should not withdraw from any federal programs at this time.

6. Comprehensive Health Insurance

Comprehensive health insurance was discussed at great length, and the Council position was upheld which is as follows: That support should continue to be given to the principles and guidelines already adopted and long supported by the House of Delegates for comprehensive health insurance and to H.R. 1818 and S.B. 218 which embody these principles.

Reference Committee C
(Deals with Medical Education)

1. Accreditation of Continuing Medical Education

The Council on Medical Education feels that the Chairmen of Continuing Education Committees in state medical associations have been and may be appointed by the Board of Trustees to the Liaison Committee on Continuing Medical Education and that these chairmen, by participating in the Annual Conference on Continuing Medical Education, will have the desired mechanism for coordinating their activities and exchanging information. This matter was reported back to the Council on Medical Education.

2. Reporting Continuing Medical Education

This is simply to report that a pilot study of reporting of continuing medical education credits will be reported at the 1978 Annual Meeting.

3. Liaison Committee on Continuing Medical Education

This deals with the fact that the Council on Medical Education expects the responsibility for continuing medical education to lie in the hands of the Liaison Committee on Continuing Medical Education. The LCCME is to maintain and strengthen close liaison with state and territorial associations that survey, review, and evaluate continuing medical education programs.

4. Nutrition Courses in Medicine

Adopted was the following resolution: That the AMA recommend that teaching of adequate nutrition courses in elementary and high schools, and be it further Resolved, that the AMA representation on the Liaison Council on Medical Education work toward enhancement of the teaching of nutrition in medical schools.

5. Minority Under-Representation in Medicine

The following resolution was referred back to the Board of Trustees: That the AMA investigate ways to meet goals for the enrollment of minority medical students.

6. Relationships between Medicine and Nursing

This report should be referred to our Joint Practice Committee for their review and consideration.

7. Essentials of Approved Residencies

a. Family Practice

Report L of the Council on Medical Education concerns itself strictly with the special requirements for residency training in family practice and was accepted. These should be a part of each hospital's specialty requirements, and such can be obtained from the AMA.

b. Ophthalmology

This concerns similar essentials of an approved residency in ophthalmology, and similarly this should be kept in record in all hospitals for such residencies and can be obtained from the AMA.

c. Therapeutic Radiology

This concerns essentials of approved residency pertaining to therapeutic radiology. Again, such should be with each hospital staff concerned with such residencies.

d. Pediatrics

This is a guide also to hospitals for the essentials of approved residency in pediatrics.

Reference Committee D

(Deals with Hospital and Medical Facilities)

1. Primary Responsibility for Hospitalized Patients

Basic recommendations in this field are listed in the Board of Trustees Report H under five items. (1) The determination of which physicians and other classes of health care practitioners shall be granted clinical privileges in the hospital shall be established at each particular hospital in accord-

ance with community needs and applicable state laws and regulations. (2) Irrespective of whether the purpose of a hospital admission is to provide surgical or other services by a physician, dentist, or podiatrist, all patients are entitled to the enforcement of safeguards to assure reasonably uniform, satisfactory standards of care even though the means of providing this protection may differ.

2. Voluntary Cost Containment

Report TT of the Board of Trustees contains proposed plans relative to achieving effective cost containment. This should be brought to the attention of all physicians throughout the state.

3. Guidelines for Physicians Attending Patients in Long-Term Care Facilities

Here are 22 guidelines that should be looked at by the entire membership of the Medical Society of Delaware. This can probably be best handled in our *Newsletter*.

4. Physicians' Offices in Hospital-Owned Buildings

Taken from Judicial Council Opinions and Reports, page 40 of the 1977 edition, the first statement is the conclusive one: An arrangement by virtue of which a physician leases office space for a percentage of gross income is not acceptable and is in violation of ethical principles. The practice directly results in fee splitting and tends to exploit the practice of medicine.

5. Medical Staff Selection of Representatives on Hospital Boards of Trustees

The final resolution is the clincher. Resolved, that one of the best means of communication between a medical staff and the governing board of a hospital is by having medical staff members on the governing board chosen from a list of physicians elected by the medical staff.

6. Elimination of the 60-Day Recertification Visit to Nursing Homes under Title XIX of the Medicaid Regulations

This was rejected. It had been requested that the physician only be required to certify the medical necessity for a visit to the patient, but the House of Delegates upheld HEW's regulation for the 60-day recertification.

Reference Committee E

(Deals with Scientific and Public Health Questions)

1. Patient Instructional Leaflets

The Council on Scientific Affairs listed two statements with eight substatements under the first statement. These are important enough that they should be brought to the attention of the Medical Society as a part of Report E and can probably again be asserted in our *Newsletter*.

2. Consideration of the Use of Amphetamines in Obesity

The Council's recommendation was accepted as follows:

1. That the FDA be advised that a change in the patient package insert instructions on CSA No.

II amphetamine use in the short-term treatment of obesity is unnecessary and would constitute an unwarranted intrusion by a regulatory agency in the practice of medicine.

2. That the Drug Enforcement Administration of the Department of Justice be offered every encouragement in the prosecution of those individuals who prescribe CSA No. II amphetamine drugs for non-medical reasons in order to profit at the expense of patients who are drug-dependent.

3. Council's Report D on Health Aspects of Marijuana

The report was amended in several instances and when the final report comes from the AMA with the amendments, our Society would do well to be sure that this entire report is in some way circularized to those who are interested in drug abuse and in the merits and demerits of marijuana.

4. Definition of Statutory Death and Legal and Medical Definition of Death

The House of Delegates passed a resolution that it reaffirms the established policy that "death shall be determined by the clinical judgment of the physician using the necessary available and currently accepted criteria" and "permanent and irreversible cessation of function of the brain constitutes one of the various criteria which can be used in the medical diagnosis of death;" and be it further *Resolved*, that in those states where legislation is supported to recognize the legality of determination of death based on irreversible cessation of brain function, that provisions be included to assure the physician's right to exercise his medical judgment in diagnosing death and to employ other medically recognized procedures and criteria in determining the time of death.

5. Promotion of Exercise

The House of Delegates went on record as promoting exercise with adoption of a resolution that the Board of Trustees consider the feasibility of developing a public and professional education program emphasizing the advantages of regular exercise and report to the House of Delegates at the 1978 Annual Meeting.

6. Consent Calendar/Waiver of Debate

Committee E finished its work in ten different items with the use of a consent calendar with a waiver of debate. This was to be challenged for debate if any member, any single delegate, so desired. Of the ten items the Committee recommended adoption of four, filing of four, referral of one, and no adoption of one. It went through unchallenged and looks like a very excellent mechanism that we could use in our Board of Trustees. (Doctor Egan tried this in part earlier but was not as complete as this idea, and I think that (1) the Executive Committee of the Board of Trustees could review many bills, giving their reaction to them as long as they were circularized long before our meeting, and await challenges if such were

the case or (2) we could have the Board of Trustees recognize that acceptance would be blanket unless challenged. This could, once we got used to the mechanism, I believe, speed up our meetings.

(It did for the House of Delegates.)

Reference Committee F

(Deals with Finances and Handling of the Business of the Board of Trustees)

1. Criteria for Billing for AMA Membership

The House of Delegates accepted criteria for AMA billing, which will be sent to the Board of Trustees for further review, but in all likelihood they will also be sent to the medical societies for them to understand fully the process. (Report V of the Board of Trustees.)

Most items this time considered by Reference Committee F were housekeeping matters and do not have any further need for discussion, unless some member of our Board so requests.

Reference Committee G

1. The Impaired Physician

The report refers to the 1974 model bill. In reviewing my 1974 notes I cannot find anything more than a reference to a model disabled physician's bill. For our Committee considering this matter, it would be well if our Executive Director could dig out that model bill and give it to Doctor Levitsky.

2. Women Physicians in Organized Medicine

The following resolution evolved: That the AMA undertake a study to determine the number of women physicians who, at present, hold elective or appointive positions in the AMA and its component societies; and be it further *Resolved* that the Association analyze this information and other available data about women physicians and develop plans of action to increase participation of women physicians in the activities of organized medicine.

3. Cardiac Life Support

This brought about a resolution: That the AMA recommend that all licensed physicians become and remain proficient in basic Cardio-Pulmonary Resuscitation (CPR); and be it further *Resolved*, That the AMA recommend that all licensed physicians become proficient in Advanced Cardiac Life Support commensurate with their responsibilities in critical care areas.

Reference Committee H

1. The Role of Reference Committees in the AMA House of Delegates

The House passed a resolution that the official policy should at all times seek to reflect the considered opinions of the Association's physician members, and further resolved that the members of the reference committees should make informed decisions on the basis of the testimony heard in open hear-

ings and on the basis of background information supplied by resource personnel with the full understanding that the recommendations developed are the responsibility of members of the reference committees.

1978 ANNUAL MEETING

Prior to the meeting, Mrs. Bader and I made application to have E. Wayne Martz, M.D., considered for the Coordinating Council on Medical Education. Mrs. Bader received confirmation from Dr. Richard Egan that Dr. Martz would be considered in the fall while I received a letter of support for our candidate from Hoyt D. Gardner, M.D., the president-elect.

Important to our Society was the Southeastern States' Coalition. Two events were scheduled. On Sunday, June 18, 1978 delegates and officers of Alabama, Delaware, Georgia, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, and Virginia had breakfast and stayed to listen to all the candidates for the offices of the AMA. On the surface this came off as a "bust" until we reflected on the voting results. The Southeastern States had six men seeking office and had five elected, losing only Dr. George E. Burch for the Council on Scientific Affairs. Dr. Burch is from Louisiana. The interviews were too long and were attended best by Delaware's three representatives.

It was good on Wednesday, June 21, 1978, to see Delaware's name near the top of the hosts' board as sponsors of one of the best events of the meeting, luncheon for all members of the AMA present that day. This constituted the tangible evidence of our involvement in the Southeastern States' Coalition. We can hope Dr. Martz's candidacy is supported by these states as shown at this meeting.

The elections selected these men: Tom E. Nesbitt, M.D., president; Hoyt D. Gardner, M.D., president-elect; William Y. Rial, M.D., speaker; Harrison L. Rogers, Jr., M.D., vice speaker; Joseph F. Boyle, M.D., Charles Max Cole, M.D., Robert B. Hunter, M.D., William S. Hotchkiss, M.D., and George A. Rowland, M.D., trustees. To the Councils the following were elected: Constitution and Bylaws—Ralph M. Millikin, M.D., and Peter R. Petrich, M.D.; Medical Education—Eben Alexander, Jr., M.D., Russell S. Fisher, M.D., J. Jerome Wildgen, M.D., and Charles N. Verheyden, M.D. (resident member); Medical Service—George E. Collentine, M.D., Robert T. Kelly, M.D., Robert E. McCurdy, M.D., and Malcolm O. Scamahorn, M.D.; Scientific Affairs—John R. Beljan, M.D., Theodore Cooper, M.D., Stanley J. Dudrick, M.D., and C. John Tupper, M.D.; Judicial Council—John H. Burkhart, M.D.

The Aetna Group States had no formal meeting at this convention, but it was learned that we are now a group of only eight states. Utah dropped out to form its own company. West Virginia assured us

they were satisfied, but Washington admitted they were watching the Utah results with great interest. Aetna, it is said, would not oppose Utah but would enter into direct competition with Utah.

Three hundred reports and resolutions were considered by the House of Delegates. For this report we will divide the actions according to the Reference Committee's Reports on the floor of the House of Delegates.

Reference Committee on Constitution and Bylaws

1. Additional specialty representation was voted for American Geriatrics Society, American Society for Clinical Pharmacology and Therapeutics, Congress of Neurological Surgeons, Society of Medical Consultants to the Armed Forces, and the American Council of Otolaryngology.
2. AMA Principles of Medical Ethics were revised and the revision presented to the House with the recommendation to have a House Committee study and report back to the Interim '78 Convention with its recommendation. This seems fitting, since ethics developed by the Judicial Council and later judged by the Judicial Council would only be suspect. More comment is needed on this subject from the grass roots to each state society and thence to the committee composed of these physicians: James S. Todd, M.D., Chairman, of New Jersey; H. Thomas Ballantine, Jr., M.D., Trustee from Massachusetts; Amos P. Bratrude, M.D., of Washington; John J. Coury, M.D., Trustee from Michigan; Jean F. Crum, M.D., of California; Henrietta Herbolsheimer, M.D., of Illinois; Joseph T. Painter, M.D., of Texas; and Carroll L. Witten, M.D., of Kentucky.
3. The New Decimalization of the Bylaws was adopted intact.
4. A resolution was adopted to later amend the Bylaws to require the election of a resident member to the Council on Constitution and Bylaws for a term of three years with a right to vote. (First election in June 1979)
5. A reorganization of the Student Business Section was adopted.
6. The Board of Trustees was asked to study further the National Commission on the Cost of Medical Care recommendation No. 5.

Reference Committee A

(Deals with Insurance and Medical Service)

1. *Resolved*, that the AMA continue, through its publications and other appropriate means, to inform physicians fully of the provisions of Title XIX of the Social Security Act and of the application of these provisions to their practices; and be it further

Resolved, that any "provider agreement" (between the State Medicaid and the provider) should include the phrase "the auditing of a physician's

records should have informed written consent of the Medicaid patient."

2. Probably, it would have kept the National Commission on the Cost of Medical Care Report in better form, if each item had been handled chronologically by one special committee; this was not the case. Here is a listing of House Action on the Recommendations assigned to Reference Committee A:

(a) Adopted with the Board's response were Recommendations 1, 2, 4, 8, 9, 11, 14, 23, 25, 27, 28, and 41.

(b) Referred to the Board for further study were Recommendations 15, 28, and 3. Three would assess HMO's and IPA's with a plea for fair marketing among all systems of health delivery.

3. A move away from the PSRO concept was reaffirmed:

Resolved, that the AMA urge all health insurance carriers and government health care financing agencies to rely on appropriate resolution of all matters concerning the quality, cost, or utilization of medical services which require professional judgment; and, be it further

Resolved, that peer review programs shall have as their goal both improved quality of medical care and more efficient delivery of medical services.

4. Concern for health care in rural America was expressed by

Resolved, that the AMA express its continuing concern for medical and health needs of citizens in rural America, particularly those problems resulting from inadequate consideration of special rural problems in health planning guidelines and from discrepancies in reimbursements to providers in rural areas, and continue to seek remedies to these problems.

Reference Committee B (Deals with Legislation)

1. This committee referred to the National Commission on the Cost of Medical Care Report as the Board of Trustees Report A and approved all the Recommendations presented to it, namely, Recommendations 6, 7, 16, 17, 18, 19, and 24. Doctor Roger Thomas spoke out against 19 and thought it should be rejected totally. The Recommendation was referred back to the Board of Trustees for further study.

2. In completing this report of Committee B an outline or worksheet was used by Doctor Thomas that helped to quickly review the material and to note Rog's opinions and reactions. Similar worksheets would be of aid to us in the future. Mrs. Bader has seen the ones we used and promises to construct such sheets for future meetings.

3. A resolution was passed opposing certificate of need extension to physicians' offices.

4. Resolution 58 amended demanded that the AMA use its influence with the federal government to

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refrain from implementing further regulations and health care systems without supportive evidence of positive impact upon the quality of care and cost containment.

5. The anger of the House was displayed in reversing the reference committee on Resolutions 110 and 113, which asked Congress for more physicians on HSA's and in turn asked that HEW be exposed for its impact on health care economy through its regulations.

6. Resolution 115 concerned with optometric services in V.A. hospitals was referred to the Board of Trustees. It would be well to pass this on to the ophthalmologists of our state and encourage their input to the Board of Trustees in this matter.

7. Many resolutions were referred to the Board of Trustees concerning the introduction of AMA-sponsored NHI in the next Congress.

8. The House went on record with a substitute amended resolution 51 supporting an amendment to the U.S. Constitution prohibiting deficit spending.

Reference Committee C (Deals with Medical Education)

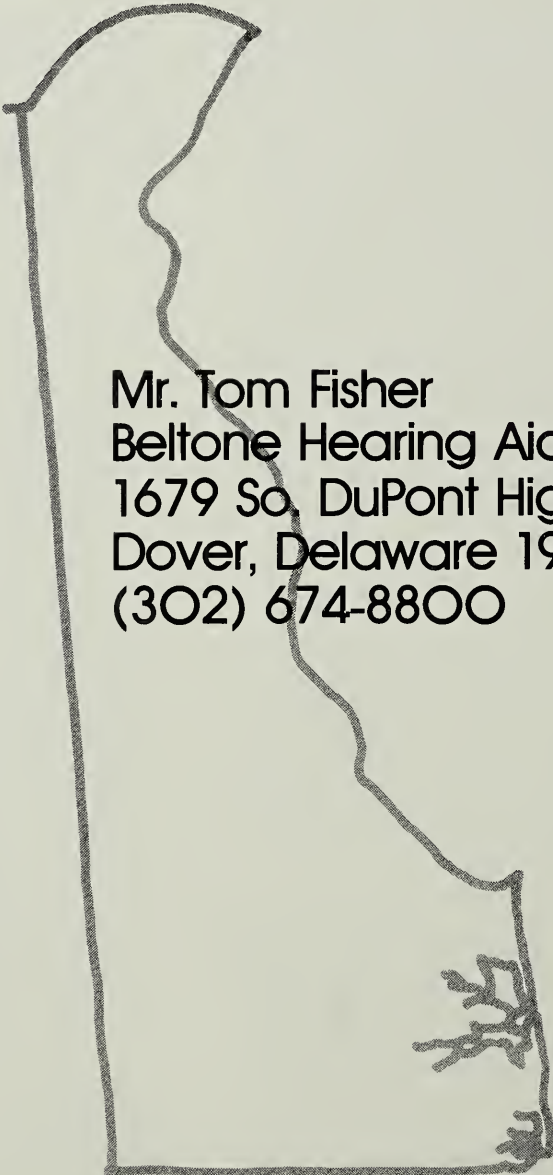
Committee C took care of the recommendations from the report of the National Commission on the Cost of Medical Care assigned to it and in numerical order. It should be emphasized here that adoption of

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the Board of Trustees' responses for the most part meant only referral for further consideration. Referral occurred with recommendations 21, 33, 34, 35, 36, and 37; 38 was adopted. Recommendation was further hedged, in that, through joint consideration with the Council on Medical Education Report B, it was emphatically claimed that no new efforts should be made to increase the number of medical school graduates until a necessity for change is clearly made evident. Report B on Physician Manpower is a 67-page set of information covering the needs for further medical manpower and placement plus schemes of education for this manpower spread.

Committee C referred to the Board of Trustees the following resolutions: Consideration of defaults by medical students on education loans (21); due process (163); locum tenens (105); and use of technical assistants in operating rooms (6). These subjects are open to our reaction by writing comments to the Chairman of the Council on Medical Education.

Adapted and made policy for us to live with until the meeting of December 1978 were:

1. AMA encourage emphasis of cost consciousness among medical educators (Res 24 and 43);
2. Establish basic courses in nutrition (Res 116);
3. Approval of "Special Requirements" for programs in graduate medical education (Report C of the CME);
4. Asked AMA through the Council on Medical Education to identify residency training programs that inadequately train physicians in their particular specialty (Substitute for Res 102);
5. Abolishment of VISA qualifying exam for FMG's (Res 69);
6. Stress and react to the unfairness of Public Law 94-484, Title VI (Substitute for Res 109);
7. Further explanation of continuing medical education accreditation (Report G of CME);
8. Status of U.S. continuing education (Res 161) and asked for cost control within continuing medical education (Res 53).

Also adopted were resolutions 55 and 160, CME Reports D, E, F, I, J, and M and Board of Trustees Report BB.

Reference Committee D

(Deals with Hospital and Medical Facilities)

Committee D's presentation suggested that the House accept only in principle the National Commission on the Cost of Medical Care Recommendations 10, 12, 20, and 39 while adopting and referring Recommendation 13. Strikes in the health care system were discussed in the adopted Board of Trustees Report H. Other reports adopted were Board of Trustees Reports H, FF, and Report E of the Council on Medical Service.

The resolutions considered by this committee and the House of Delegates were:

1. Standards for Hospital Emergency Departments (Substitute Res 13);
2. Referred review of hospital emergency services (Res 27);
3. Asked that any cost containment recommendations adopted by the AMA be applied equally to federal and state hospitals (Res 28);
4. Agreed to voluntary health care cost containment (Res 34);
5. Patient Safety Programs in our Hospitals adopted (amended Res 54);
6. Resisted unilateral action of hospital boards of trustees in governing hospital medical staffs (amended Res 62);
7. Asked that a physician be on any and all JCAH inspection teams (Res 82);
8. Opposed rate review commission (Substitute Res 94).

Reference Committee E

(Deals with Scientific and Public Health Questions)

It is difficult to account for the National Commission on the Cost of Medical Care Recommendations that were considered by Reference Committee E. The fact that these recommendations were tangentially related to Public Health must be the excuse for their being assigned to Committee E. As a result of the deliberations of Committee E and its presentation to the House these actions followed: Recommendations 44, 45, 46, and 48 were approved; approved in principle were Recommendations 29, 31, and 47; approved and referred to the Board of Trustees was Recommendation 32, and referred were Recommendations 42 and 43.

Council on Scientific Affairs Reports were adopted, covering these subjects:

- Report A—Use of Barbiturates in Medical Practice;
- Report B—Heroin Reclassification;
- Report C—Health Evaluation of Energy-Generating Sources;
- Report D—Medical Implications of Motorcycle Helmet Usage;
- Report E—Adoption of International System of (S.I.) units for Clinical Chemistry;
- Report F—on the reliability of laboratory procedures was filed.

Resolutions 4, 5, 8, 99, and 130 were referred to the Board of Trustees; these resolutions dealt with such varied problems as liability for vaccine reactions, establishment of center for health care technologic data, principles of quality mental health care, and prescriptions for contact lenses.

Substitute resolutions for resolutions 11, 18, 30, 31, 47, 50, 56, 65, 66, 79, 91, 98, 149, and 159 covered the following subjects: computerized donor registry, curbing of cigarette smoking, physicians' desk reference, federal regulations on sterilization, support of education to promote healthful lifestyles, starting

health education early, health education of the public, opposition to waiting period in sterilization guidelines, development of health education programs, neglect of the chronically mentally ill patient, blood banking, opposition to restrictions on public funding of abortions, and federal tax on cigarettes.

Adopted after amendment were Resolution 37 dealing with AMA membership on the American Blood Commission and Resolution 95 dealing with the hospice concept.

Adopted were the resolution that the AMA advise Congress as to the insufficient support being directed toward basic research in comparison with other health-related projects (Res 81) and the resolution that the AMA support the concept of emergency training in secondary schools to include simple effective resuscitation techniques (Res 157).

Reference Committee F
(Deals with Board of Trustees)

Based on review by Reference Committee F the House of Delegates filed the Board of Trustees Report E, the Auditor's Report; F, AMA Contracts; and CC, AMA 1978 National Advertising Campaign. The House also filed the report of the Executive Vice President, James H. Sammons, M.D., and the address of the retiring President, John H. Budd, M.D., and the Report of the National Commission on the Cost of Medical Care.

The House of Delegates agreed one hope for cost containment in the provision of health care lies in strengthening price consciousness in the health care marketplace.

Adopted were the Board Reports D on AMA dues and DD on reduced dues for physicians in their first few years of active practice.

Resolutions 9, 19, 20, 87, 131, and 140 concerned with cost of medical care, AMA leadership in addressing Medical Cost problems, support of individual practicing physicians, AMA public relations program, commendation for national advertising program, and the National Commission on the Cost of Medical Care were adopted.

It was resolved that the AMA continue to pursue appropriate legal recourse to prevent the Department of Health, Education and Welfare from releasing the names of individual physicians and their income information contained in Medicare records.

Referred were Resolutions 77 and 78 about recruitment, reduced dues, and medical school faculty members.

Reference Committee G (Miscellaneous)

Report B of the Board of Trustees was adopted; hence the House of Delegates will officially use the Consent Calendar.

The Report of \$2,763,421 total income by the Education and Research Foundation was filed.

Adopted Resolutions were 29, 40, 61, 101, 132, and 158. These resolutions established action in these subjects: misuse of term "Medical Care," all society responsibility for cost effectiveness, cost containment criticism from the President of the United States, AMA area meetings, and distribution of the Principles of Medical Ethics.

Resolution 123 (AMA Newsletter), Resolution 73 (Ad Hoc Legal Assistance Committee), and Resolution 162 (An AMA Medical Student Loan Program) were referred to the Board of Trustees for further action.

Reference Committee H (Miscellaneous)

Deliberations of the House guided by the report of Reference Committee H led to the conclusions that follow:

1. Adopted Recommendation 30 of the National Commission on the Cost of Medical Care and Report Q of the Board of Trustees on liability for development of products to reduce health hazards;
2. Referred Report G on Human Rights of the Board of Trustees;
3. Referred Resolution 16 on tax-free trusts for payment of professional liability judgments;
4. Filed Report I of the Board of Trustees on Professional Liability;
5. Adopted Resolution 80.

After each was amended, resolutions 89, 122, and 164 were adopted. The subject matter of the above resolutions was: Warning labels on alcoholic beverages, reinstatement of AMA Committee on the Medical Aspects of Sports, medical disability retirement, and violence against women.

This concludes my report for the 1978 Annual Meeting held in St. Louis, Missouri.

RHOSLYN J. BISHOFF, M.D.
Delegate

**REPORT OF THE PRESIDENT OF THE
SUSSEX COUNTY MEDICAL SOCIETY**

Routine meetings were held as usual with guest speakers most of the time. It is important to emphasize the better attendance this year than in the previous years. This could be attributed to the greater interest of the county physicians or to Dr. Dyer in Milford, Dr. Alvarez in Seaford, and me in Lewes contacting most of the physicians personally to urge attendance at such important meetings.

Generally speaking, the membership is more interested about the meetings than before most likely because of the present atmosphere in medical politics, especially with the threat of national health insurance

coming in and different changes in the medical structure. In view of showing more interest, the members voted at the last meeting to have the Executive Committee meet once a month in order to discuss the problems of the county and also with the Medical Society. The members, as usual, were informed about the decisions made at the County and State levels.

Of special interest in our Society was the situation with the so-called Mid-Sussex Medical Center. I am sure you are aware of this area which we discussed at the Board of Trustees a few times. In summary, the Medical Society took a stand against this proposed project to have two family physicians in Millsboro, Mid-Sussex area. The interesting part about it was that we did accomplish something: a better communication and liaison between the membership and the community. As far as I recall, we did not have satisfactory communication before this project surfaced. The community members were acting on their own and did not consult the local physicians about their problems; however, they were in touch with hospital administrators, etc. My approach to that was rather successful by having direct contact and relationship with the Board of Trustees of the Mid-Sussex Countians and also with other community leaders generally. We had a few meetings. They came to my office for a meeting, and I did attend their meeting in Millsboro, and we had mutually beneficial discussions. I do believe this is an excellent way to solve the problem between the medical profession and the community—to have direct relationship and communication. After complaint, the physicians did improve the service for the area. So far, as you know, the project is still in the period of planning and waiting for approval from HEW.

A. SALIBA, M.D.
*President, Sussex County
Medical Society*

DELAWARE ACADEMY OF MEDICINE

Your representative to the Delaware Academy of Medicine this past year has kept abreast of the activities of the Academy. There has been a continuing demand on the physical facilities of the Academy. The Delaware Affiliate of the American Diabetes Association relocated in order to acquire additional floor space. The Delaware Chapter of the American Cancer Society is now occupying the space made available by the Diabetes Association's move. Other groups continue to indicate interest in office space in the building, if and when additional space becomes available. Also, there continues to be a need for a medium-sized conference meeting room for groups of between 25 and 35 persons.

Maintenance of the building continues to place heavy demands on the finances of the Academy.

The Delaware Academy of Medicine has, for many years, published a monthly calendar of medical, dental, and scientific meetings for distribution to the staffs of hospitals, the members of the Medical and Dental Societies, and numerous other companies, institutions, agencies, and individuals. The main source of funding (DIMER) for this publication was discontinued after publication of the June 1977 calendar. Contributions were solicited from the hospitals in the State, the voluntary health service organizations, (e.g., American Cancer Society, Delaware Lung Association), and several professional organizations. Many responded favorably, allowing the continued publication of the calendar. The format has been changed to indicate continuing education credits. It is now sent through bulk mailing; distribution is currently over 1,200 copies.

The Delaware Academy of Medicine and 14 other area libraries are members of the Wilmington Area Bio-Medical Library Consortium. This group recently published a revised comprehensive listing of their holdings using a computer for the first time. The purpose of this consortium is to share freely within the structure of each of the individual libraries' policies. The Academy's library remains a depository of medical literature for the State of Delaware. The major concern remains the escalating costs of the subscriptions to periodicals and new books. The library continues to be used by its members, students in the allied health professions field, the public and other area libraries.

Life memberships were resolicited this past year. Nineteen members have responded to this appeal. A concerted effort was made to increase membership among the physicians and dentists in the State. This resulted in over 165 new members.

The annual three-day Infectious Disease Symposium was held at the Academy in May for the 15th year. This conference is co-sponsored by the Academy, the Wilmington Medical Center, and the Delaware Lung Association. Attendance continues to be very high, and the Academy's facilities are used to capacity. In November, the Warren Lecture was held as an all-day seminar in place of the customary evening lecture. It was very well attended by the health professionals in the area.

The annual banquet was held in February. The speaker was Professor A. D. Moore from the University of Michigan. His lecture/demonstration was entitled "Ben Franklin Revisited—Electrostatic Phenomena." The Life Members of the Academy were honored at the banquet.

The Student Financial Aid Program continues to aid Delaware students preparing for careers in medicine, dentistry, or allied health fields. Approximately 35 loans are awarded each year. The Committee also has continued to administer the DIMER grants which

are awarded to the Delaware-Jefferson students on the basis of need.

The Delaware Academy of Medicine, in particular the library, requests the continued support and interest of the medical community.

JOSEPH W. ABBISS, M.D.
Representative

MEDICAL SOCIETY OF DELAWARE AUXILIARY

The theme of the past year was "Delawareness: Patterns—Progression." This year is the 50th Year for the Auxiliary and therefore is the "Golden Jubilee Year," and a very important one. The theme, with the approval of the Board of Directors, will be "In Unity There Is Strength."

Membership—"Personal Auxiliary Link" letters were mailed to prospective members with good results. Membership is now 309.

Counties—There are three counties in the State of Delaware: New Castle, Kent, and Sussex; however, only two are active, with Kent County not organized. This is a challenge, and every effort will be made in the coming year to help the 17 dues-paying members to re-form a meaningful organization.

AMA-ERF—The amount reported was \$3,089.01 earned through usual channels by auxiliaries.

Legislation—A letter opposing the Federal Election Campaign Act Amendment of 1978 was sent to our Congressman. DELPAC was reactivated with 71 of its 161 members doctors' wives.

Project Bank—Three special events, Dinner Theatre, Fashion Show, and International Covered Dish Supper, were deposited into Project Bank. The name is now changed to Health Project Bank, and information has been condensed.

Community Health Services—During Governor duPont's Health Week, auxiliaries assisted by taking blood pressures of the public. Breast screening totalled 600 man hours, and many hopscotch courts to promote immunization were stencilled in school areas.

Mental Health—Rape against women and child abuse workshops were held even though poorly attended.

International Health—Anesthesia equipment, textbooks, surgical instruments, and dental equipment were sent to a Guatemala medical clinic.

Meetings—Four Executive Board Meetings, four state officers and chairmen meetings, and a state conference workshop were held last year. Four board and state officers meetings will be held in this coming year.

Delaware was represented at national meetings and neighboring state meetings by the President and Presi-

dent-elect. The Immediate Past President and President attended the American Medical Association Auxiliary meeting in St. Louis, Missouri, in June. The state meetings of New Jersey, Maryland, New York, and Virginia will have presidential representation this year.

The enthusiasm of the women who will serve as chairmen is infectious, and I find myself looking forward to the year ahead with eagerness. "In Unity There Is Strength" shall be a goal that we shall achieve, and our Golden Jubilee Year will be remembered as a significant one.

JOAN M. WOODEN
*President, Medical Society of
Delaware Auxiliary, 1978-79*

REPORTS OF THE STANDING COMMITTEES

BUDGET COMMITTEE

The Budget Committee on July 21, 1978 and in subsequent conference proposed for consideration by the Board of Trustees and the membership total expenditures of \$141,080.00 with anticipated revenues of \$141,080.00. A 15% rise in total expenditure over the 1978 budget reflects in large part (50%) the addition of one part-time staff position and the increased employee pension reserve necessary with the eligibility this year of one more individual. The remainder of the increases are in office management costs, insurance, and Ned Davis Associates (last year's fee escalation that was not budgeted in 1977-1978).

The Chairman wishes to thank Committee members Doctors Brooks, Dyer, Hilty and Wilk for their advices.

MEDICAL SOCIETY OF DELAWARE BUDGET 1978-1979

RECEIPTS

Dues	\$ 124,080.00
Dividends and Interest	17,000.00

Total Receipts	\$ 141,080.00
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DISBURSEMENTS

Office Personnel

Employee Benefits	\$ 7,000.00
Salaries	70,700.00
Employer Tax	3,700.00
Hospitalization	4,160.00

Office Operation

Contribution to Academy	\$ 8,200.00
Printing, Postage, Stationery,	

Telephone, Supplies	15,000.00
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Audit	1,400.00
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Insurance and Contracts	7,500.00
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Travel

AMA Delegate and Contingency	7,500.00
Committees and Contingency	5,200.00

Subscriptions and Dues	720.00
Contributions	1,000.00
Ned Davis Associates	9,000.00

Total Disbursements	\$ 141,080.00
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Special Funds

Education Fund*	\$ 3,300.00
Delaware Medical Journal	
Subscriptions	6,600.00
Medical Defense Fund	660.00
Medical Benevolence Fund	660.00

*\$2,000.00 donation from the Education Fund for the Academy of Medicine Library.

PETER R. COGGINS, M.D.
Chairman

(This report was filed.)

BYLAWS COMMITTEE

The Bylaws Committee worked on a complete revision of the Bylaws of the Medical Society of Delaware. Their work product is submitted for approval by the House of Delegates.*

C. E. GRAYBEAL, M.D.
Chairman

*A copy of the revised Bylaws will be distributed to each member in the 1979 Pictorial Roster and therefore will not be printed here.

MEDICAL ECONOMICS COMMITTEE

The Medical Economics Committee met early in 1978 to discuss the insurance programs of the Medical Society of Delaware. This meeting was attended by representatives from Blue Cross-Blue Shield and J. A. Montgomery.

The representatives from Blue Cross-Blue Shield were instructed to submit alternate proposals for hospital coverage other than the present programs subscribed to by members of the Medical Society of Delaware. These primarily involve a deductible type program and also the addition of major medical coverage.

The J. A. Montgomery representative was instructed to contact other insurance carriers to determine whether or not they would be interested in writing disability income insurance for the members of the Society. The representative has informed the Committee that there has been insufficient interest in the major medical program drawn up by J. A. Montgomery and efforts to institute such a program were being abandoned.

There has been little progress to report on the above-mentioned programs. Blue Cross-Blue Shield submitted incomplete information on alternate types of coverage. We have been unsuccessful in obtaining other carriers who might be interested in providing health insurance for the members of the Society. J. A. Montgomery has been unsuccessful in interesting other carriers in providing disability income insur-

ance, and other insurance brokers contacted have submitted proposals for disability income insurance which were less desirable than the program we now have in effect.

The Chairman will continue to pursue these avenues and attempt to obtain definitive answers to the questions posed at the Medical Economics Committee meeting this year.

OLIN S. ALLEN, II, M.D.
Chairman

(This report was filed. The House noted the Reference Committee's recommendation that in the future the Medical Economics Committee should be more aggressive in pursuing alternative agents and insurance companies.)

MEDICAL REVIEW COMMITTEE

During the preceding year, the Medical Review Committee met three times. In addition to these meetings of the full Committee there were numerous meetings of smaller working groups drawn from the Committee to address specific problems.

Of the greatest significance was the Committee's work in cooperation with Blue Cross-Blue Shield of Delaware Inc. to supervise and retard the rate of increase of physicians' filed fees under the Blue Shield prevailing fee contract. The results of the preceding year's agreement with Blue Shield were evaluated and a similar agreement reached for the current fiscal year.

A few appeals to this negotiated settlement were received, and these appeals were individually heard and decided.

The nature of the Committee's work has altered significantly in the last several years. In the early years of this Committee's work, most of the Committee's efforts were directed towards resolving fee disputes in individual cases. This type of work has almost completely vanished. This would indicate that physicians and the Plan are having fewer disagreements over compensation for individual services or that they are working out these disagreements satisfactorily without resort to the Committee.

The Committee is still called upon to establish fees for new procedures which have no established prevailing fee.

JOSEPH E. BELGRADE, M.D.
Chairman

MEDICAL SERVICES INSURANCE COMMITTEE

The Medical Services Insurance Committee met twice during the previous year. The first meeting was devoted entirely to consideration of the Blue Shield proposal for a method of handling the filed fees for the year 1978. At its second meeting, the Committee considered a proposal designed to increase the number of specialties which would be recognized

by Blue Shield for fee filing purposes. At this meeting, some areas of alleged inequities in the remunerations received by various specialties were considered. No specific recommendations were made, but this area is still under study.

As in preceding years, the specific role of this Committee is difficult to assess because its functions are so similar to those performed by the Medical Review Committee. The Society might consider merging these two groups so as to alleviate this confusion.

JOSEPH E. BELGRADE, M.D.
Chairman

PEER REVIEW AND PROFESSIONAL EVALUATION COMMITTEE

One meeting was held, on May 17, 1978. It was noted that there is a lack of a mechanism for patients in Kent and Sussex Counties to register complaints. It was suggested that the Medical Society of Delaware's telephone number be listed with the names of the Kent and Sussex Counties Medical Societies so that calls can be taken during office hours.

Discussion was also held on the lack of D.O. representation on the Committee. It is recommended that the President of the New Castle County Medical Society appoint a D.O. to the New Castle County Peer Review Committee and hence to the State Society.

The New Castle County Peer Review Committee is an active committee with regularly scheduled meetings. The Committee in Kent and Sussex Counties are not currently active.

It is my opinion that a useful peer review committee at the State level cannot exist without the enthusiastic participation of Kent and Sussex Counties. It is my recommendation, therefore, that these committees be upgraded. The State Peer Review Committee will meet at least twice a year.

JANE C. STRAUGHN, M.D.
Chairman

(This report was filed. Referred to the Board of Trustees were recommendations that more active Peer Review Committees be established in Kent and Sussex Counties and that a telephone listing be placed in the Kent and Sussex directories regarding the existence of the Kent and Sussex County Medical Societies.)

PROGRAM COMMITTEE

The Program Committee has put together what they consider to be a program that should be both informative and entertaining for the physicians of Delaware. It was our feeling that one of the main purposes of the Program Committee was to encourage attendance at the Annual Meeting. To this end, a program was arranged to hopefully interest any physician whether he be a generalist, subspecialist, internist, or surgeon.

In order for the Committee to run smoothly in

the future, I would make the following suggestions:

1. The Committee chairman should be chosen approximately a year and a half in advance to allow sufficient time for planning.
2. The present policy whereby the Program Committee maintains full control over the choice of the program should be continued.

I would like to thank the Medical Society for the opportunity of serving as this year's chairman. I hope that the program which has been arranged proves to be stimulating, informative, and entertaining.

LANNY EDELSON, M.D.
Chairman

(Approval of this report included a commendation for the Program Committee's fine work.)

PUBLIC LAWS COMMITTEE

The Public Laws Committee met ten times during the first six months of 1978.

The Committee studied ninety-three separate pieces of proposed legislation bearing directly or indirectly upon the health of the citizens of Delaware. Fifty of those bills originated in the House, thirty-four in the Senate; nine were joint resolutions. The Committee made definite recommendations to the Board of Trustees on all but three or four of the bills studied.

Perhaps the most important item considered this year was Certificate of Need Legislation. Passage of such a bill is mandated by Federal law, but the precise terms of the bill were to be defined. The Society did exert influence so that, in the event, certificate of need legislation was adopted which should be useful to the citizens generally, and tolerable for the physicians of the State.

As in years past, one must happily avow that this Committee could hardly function were it not for the very strong support we receive unwaveringly from the staff.

ALLSTON J. MORRIS, M.D.
Chairman

(This report was filed.)

PUBLICATIONS COMMITTEE

The present volume of the *Delaware Medical Journal* is number 50; however, only the numbering system reflects an upcoming golden anniversary, for an annual numbering system was not fashionable when the *Delaware Medical Journal* began to publish. Although its publication may not have been continuous (the records are lost in antiquity), our *Journal* is thought to be one of the oldest medical journals in the country, if not the oldest. All of the issues have not been under the same rubric for just a few years ago its name was changed from the *Delaware State Medical Journal* to the *Delaware Medical Journal* because it was being assumed to be a publication of the

state mental hospital rather than the state medical society.

Last year the *Delaware Medical Journal* published 34 original papers, many adopted from local presentations; 35 different reviewers reviewed 83 different books. Although the authors of the papers presented a diverse geographic spectrum, the book reviews were without exception local assessments. Doctor George F. McInnes joined the Editorial Board. Doctors Jose Pamintuan and Edgar R. Miller, Jr., retired. Welcome to Doctor McInnes. Our sincere thanks to Doctors Pamintuan and Miller. We would like publicly to thank the Editorial Board and all other experts who diligently reviewed manuscripts submitted; the quality of our material depends in no small fact on their thoughtful suggestions.

We continue to encourage manuscripts by local physicians, especially those in training. An annual prize for the best paper submitted or published during the current year by house officers is this year being awarded to Peter Klacsmann, M.D. for his paper entitled "Cytomegalovirus Mononucleosis" and David M. Richlin, M.D. for his paper with Doctors David B. Saltzman and John S. Wills entitled, "Necrotizing Angiitis and Hepatitis in an Amphetamine Abuser."

The skilled advice and abundant assistance of the *Journal* staff is acknowledged. We could not do it without them.

ROBERT B. FLINN, M.D.
Chairman

(This report was filed.)

DELAWARE MEDICAL JOURNAL

Statement of Receipts and Disbursements

	Year Ended	1-1-78—
	12-31-77	7-31-78
Total Receipts	\$29,874.88	\$20,600.42
Total Disbursements	28,293.02	17,746.33
Excess Revenue over		
Expenditure	1,581.86	2,854.09
Savings Account No. 1	10,854.87	11,448.97
Savings Account No. 2	323.04	40.70
Due to General Fund	7,558.25	7,558.25

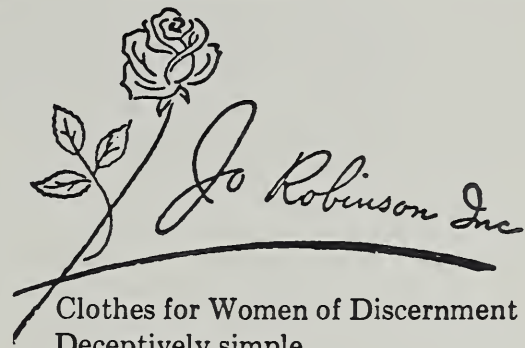
ANNE SHANE BADER
Business Manager

(This report was filed.)

REPORTS OF SPECIAL COMMITTEES

COMMITTEE FOR THE IMPAIRED PHYSICIAN

It has been estimated that about 10% of physicians in the United States are impaired in their abilities to practice by reason of drug (including alcohol) abuse, neurologic and physical impairment, or emotional disorder. For this reason, the President of the Medical Society of Delaware has appointed



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this Committee and given it the responsibility for developing a program designed to aid any such impaired physicians in Delaware.

The membership of the Committee is composed of experienced addictionologists; of physicians who are recovered from such illnesses; and of physicians who are neither of the above but who are interested in the problems of the impaired physicians and their families.

Like all others in our society, physicians fall victim to illnesses that impair their abilities to function at full potential. It is recognized that for a variety of reasons the physician tends to deny illness and, for psychological reasons, is often unable to seek professional help on his own initiative. It is the position of the President and of this Committee that the Medical Society of Delaware has a responsibility to the public at large to insure that patient well-being is not jeopardized by physicians whose competence is impaired by reason of illness.

The objectives of the Committee's program are:

- to identify and verify that a physician is impaired;
- to motivate the impaired physician to enter and to complete treatment for his illness;
- to assist the physician and the physician's family in every way possible to obtain treatment;
- to protect the physician and the family from embarrassment and hardship incident to the ill-

ness;

- to assist the physician in re-entry to practice following completion of treatment; and, finally,
- to act as friends and advocates for the physician in his relationships with hospitals, government agencies, and the Board of Medical Practice.

The Committee for the Impaired Physician is prepared to carry out their objectives in a discreet and confidential manner in an effort to dispell the "conspiracy of silence" that prevents friends, colleagues, spouses, children, hospital personnel, and others from reporting an impaired physician to the Medical Society of Delaware. Also, the anonymity of the reporting person will be protected. The approach by the Committee will be compassionate, caring, non-judgmental, non-punitive advocacy. The Committee has no official or legal connection with the state licensure body; the Committee will report to the Board of Trustees of the Medical Society of Delaware. It is recognized that despite repeated and consistent efforts, it may not be possible to persuade the impaired physician to recognize his illness and to enter into treatment. In this circumstance, such failure will be reported to the Board of Trustees of the Medical Society of Delaware, whose responsibility it will be to decide on bringing the matter to the attention of the Board of Medical Practice.

The method of operation of this Committee has been modeled after the highly successful program that has been operating in the State of Georgia in recent years. Resource material from the program of the State of Washington has also been utilized. Since this Committee is new to its work, attempts to draw on the experience and expertise of states with established programs will be undertaken. Three members of the Committee will attend the Third National Conference on the Impaired Physician — sponsored by the AMA and the Minnesota State Medical Association — to be held in late September, 1978, in Minneapolis.

The Committee has met twice — in March and in May, 1978. Reports, embracing the material contained in this report to the House, have been submitted to the Board of Trustees for their approval. At the time of this report, the Board has not authorized the Committee to begin work or to publicize its purpose.

Finally, the Committee wishes to point out that new ground is being broken by the Society in an area in which there has been no prior experience. Your patience with and your support of the Committee work are solicited.

CALVIN B. HEARNE, M.D.
Chairman

(This report was filed). The House referred to the Board of Trustees the implementation of the Committee's program and definition of guidelines for publication of information about the Committee for the Impaired Physician.)

COMMITTEE TO MONITOR HEALTH PLANNING

Because of the proliferation of health planning at the county, state, and national levels that profoundly affects all physicians in their daily practice of medicine, the House of Delegates called for the monitoring of all legislative and bureaucratic changes in the laws, rules, and regulations concerning health planning.

A new committee whose membership includes physician representatives from the Health Service Area, a member of the Public Laws Committee and the Board of Trustees of the Society, and a physician member of the Governor's Coordinating Council was formed.

The addition of one part-time staff position has become necessary because of the rapidly increasing developments with the appointment of eleven task forces working on various parts of a master health plan for the State of Delaware.

Information gathered has been disseminated throughout the year to the Board of Trustees and a meeting has been called for September 11, 1978 to review our position as it relates to the many topics under consideration.

ROBERT B. FLINN, M.D.
Chairman

(This report was filed.)

COMMITTEE ON PUBLIC AND PROFESSIONAL EDUCATION

The Committee on Public and Professional Education met on March 17, 1978, and recommended to the Board of Trustees of the Medical Society of Delaware a system whereby all programs within the State approved for Category I credit would report physician attendance by name and the number of credit hours to each physician's primary hospital which would keep a running tabulation of these credit hours. Thus the physician would be relieved of the necessity for reporting and claiming Category I credit within the State. Each physician would still have the responsibility for filing with his hospital any Category I credits earned outside of Delaware. Each hospital in turn would report annually to the Medical Society of Delaware the total number of Category I credits which each physician had earned in the previous year. A rough draft of regulations for the operation of this plan was also submitted to the Board of Trustees. The tentative anticipated date to implement this plan would be January 1, 1979.

E. WAYNE MARTZ, M.D.
Chairman

(This report was filed.)

CULTURAL AND HISTORICAL COMMITTEE

During the past year the Committee has met twice with a good representation of its members.

The following items were discussed: a) Storage,

care, and display of existing medical artifacts. At present the material is being cleaned and labeled by the Delaware Academy of Medicine staff. b) The Committee is most interested in obtaining medical equipment and discovering the necessary *who* has *what* and *where* it is.

During this fall an attempt will be made to contact the Director of Museum Studies at the University of Delaware to help the Committee pursue further methods of popularizing medical historical displays in Delaware. The Committee recommends that a medical historical journal be purchased annually by the Delaware Academy of Medicine library for the use of the Society. Oral history by means of taped interviews of senior Delaware physicians will be attempted by members of the Committee during 1979. The formation of a medical history club is continuing, and it is hoped that the first organizational meeting will be held early this fall.

ALLEN C. WOODEN, M.D.
Chairman

(This report was filed.)

DELAWARE POLITICAL ACTION COMMITTEE DELPAC

In 1978, DELPAC failed to achieve the record membership of 257 members attained in 1977. We urge consideration of joint dues billing in New Castle County because of its proven success in the other two counties. There were only eight sustaining members.

Since this is an election year DELPAC's Board has kept track of the candidates and is encouraging physicians and families to take an active part. Candidates receive a modest donation only after they request our assistance and their merits are reviewed.

This year the Medical Society of Delaware Auxiliary has taken some interest in participating after an April luncheon where Doctor Egan and a representative from AMPAC spoke of the values of physician families working toward better government and greater cooperation between politicians and medicine. Mrs. James Aikins, Co-Chairman of DELPAC, attended an AMPAC meeting regarding Federal election laws.

ROBERT ABEL, JR., M.D.
Chairman

(This report was filed.)

DELAWARE REVIEW ORGANIZATION DELRO

This report briefly highlights the major activities undertaken by DELRO between July 1, 1977 and June 30, 1978.

DELRO's utilization review and medical audit system has been implemented in the seven acute care hospitals.

The Board of Directors adopted the following corporate goals:

- Assure the medical necessity, appropriateness, and optimal quality of health care services delivered under DELRO's scope of review.
- Assure that a dollar of health care is delivered for a dollar spent, the health care delivered consisting of medical necessity, appropriateness, and optimal quality characteristics. This is cost-effectiveness and is not to be confused with cost-cutting or cost-containment, both of which may result from these efforts, but which are not specific DELRO goals.
- Remain an independent, local physician organization.
- Demonstrate accountability.
- Operate at a reasonable cost.
- Be well-managed.
- Pursue change or problem correction through education.

In an attempt to eliminate needless utilization review of unquestionably medically necessary hospital admissions, DELRO has eliminated review of approximately 40% of the hospital admissions.

To expedite patient transfer from the hospital to an appropriate post-hospital level of care, DELRO has implemented review of the need for nursing home placement while the patient is in the hospital. Data is being collected on the extent of delays in placement caused by the lack of skilled and intermediate care beds.

DELRO requested and received HEW authority to do utilization and quality of care review in the skilled nursing facilities.

Two medical audit workshops were sponsored by DELRO and featured two nationally prominent experts.

Preliminary discussions were held with Delaware's Health Systems Agency, the Delaware Health Council, to assure appropriate physician input to its activities.

CHARLES A. DEPFER, D.O.
President

(This report was filed with a special commendation regarding DELRO's elimination of review of approximately 40% of hospital admissions.)

ENVIRONMENTAL, PUBLIC HEALTH AND VENEREAL DISEASE COMMITTEE

The Environmental, Public Health and Venereal Disease Committee met on a monthly basis. The problems presented to the Committee were many and varied. The problem of nuclear waste was at least temporarily solved with the passage of H.B. 584, which restricts the storage of radioactive material to no more than one year with the understanding that waste from other states and countries would not be allowed in Delaware. The advent of a fusion system may further alleviate the present problem.

The epidemic of venereal disease, more than 5000 cases in Delaware, has yet to be solved. It was thought

that the education program would help in this regard, but so far there has been no breakthrough.

It is anticipated that the Committee will continue to act as a fact-finding body and advise the Board of Trustees on legislation and procedure when feasible.

FRANK T. O'BRIEN, M.D.
Chairman

(This report was filed. The House required that this report be filed with a copy of H.B. 584.)

HOUSE BILL NO. 584

AN ACT TO AMEND CHAPTER 74, TITLE 16, DELAWARE CODE, RELATING TO THE STORAGE OF RADIOACTIVE MATERIAL.
BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Chapter 74, Title 16, Delaware Code, by adding the following section:

"§7417. *Storage of Radioactive Material*

(a) No facility for deposit, storage, reprocessing, or disposal of spent nuclear fuel elements or high-level radioactive waste material shall be constructed or established in this State unless the Authority on Radiation Protection first finds that it promotes the general good of the State and approves, after a public hearing, a petition for the approval of such facility.

(b) No radioactive waste material shall be held in temporary storage for longer than 5 years.

(c) Whenever the Authority on Radiation Protection finds that the continued presence of a facility for the deposit, storage, reprocessing, or disposal of materials in (a) above is injurious to the public welfare, the Authority shall issue its order shutting the facility and requiring immediate removal of such material.

§7418. The Authority on Radiation Protection shall not permit the deposit in Delaware for any period of time of spent nuclear fuel elements or radioactive waste material originating in any other state."

JOINT PRACTICE COMMITTEE FOR PHYSICIANS AND NURSES

The Joint Practice Committee for Physicians and

Nurses met three times during this year. Practically all of the items discussed at these meetings involved tensions which exist between the two professions. Almost without exception, these tensions arise from efforts being made by the nursing profession to alter the role of the nurse and to increase their independence and sphere of activities. Naturally, the physicians' reaction to this effort also creates tension. During this year, the Committee explored means of improving communication between the two professions as one possible means of alleviating this problem and at the same time improving the quality of patient care.

In the coming year, it is important that the activities of this Committee be closely monitored so as to determine whether or not the Committee serves to achieve this objective.

JOSEPH E. BELGRADE, M.D.
Chairman

LIABILITY INSURANCE COMMITTEE

The Liability Insurance Committee met on August 22, 1978 to review the Medical Society of Delaware's Professional Liability Insurance Program for the seventh straight year.

Approximately 84% of the eligible membership participate in the Professional Liability Insurance Program.

Aetna continues to offer high limits of coverage (over \$5,000,000) to all members.

Review of experience and discussion with medical personnel indicate a need to change current classifications. Shock therapy will be rated Class II (currently Class III) and Liver and Kidney biopsy procedures will be rated Class I (currently Class II).

Physicians will have a choice of \$1,000,000 SCOPE (excess coverage) or other limit options.

There were a number of program improvements for the 1978-1979 year as follows:

1. to remove the partnership surcharge and the limits of liability it provided. Aetna will also eliminate the surcharge on employed physicians (where employee is an Aetna insured).
2. to offer defendants reimbursement as an optional coverage. This coverage provides reim-

LIABILITY INSURANCE RATES FOR ALL CLASSES

*CLASS	1977 PREMIUM	1978 PREMIUM	DIVIDEND	1978 NET COST
I	\$ 1,282	\$ 1,393	\$ 138	\$1,255
II	2,166	2,260	249	2,011
III	4,111	4,134	502	3,632
IV	5,313	5,342	669	4,673
V	6,613	6,650	836	5,814
VI	7,912	7,955	1,003	6,952
VIII	10,509	10,568	1,337	9,321

*Class I & II: \$1,100,000/1,300,000 III & VIII: 1,250,000/1,500,000
(Includes Premises Liability and Personal Excess (SCOPE))

bursement for necessary expenses and loss of time incurred during the policy period as the result of required attendance at trial as a defendant in a professional liability suit. Limit of liability is \$200 per day; \$5,000 per suit.

3. to shorten from 5 years to 3 years the length of time before favorable loss experience can contribute to dividends.
4. to pay interest on any expense savings dividends that are declared.
5. to return a special dividend this year (\$268,325) that considers more of the loss dollars currently being held for future claims than the present dividend program would normally consider. This is being done because of the very favorable results in the last 2 account years (1975-1976).

Rates for all classes combined will increase about 2%, removal of the partnership/corporation and employed physician surcharges will make revenue from Medical Society of Delaware about the same as last year.

Dividend—As the cumulative results of the program improved substantially since last year, \$268,325 in dividends will be returned. A \$244,424 dividend was returned last year.

Premiums—Revenue from Medical Society of Delaware members will remain about the same for the coming year.

During the period between July 15, 1977 and June 30, 1978, thirty-six new claims have arisen. This represents a decrease of six from the previous period. During the full life of the program, the arisings by policy year have been as follows:

Policy Year	Arising	Closed	Open	Suits
1971-72	21	19	2	14
1972-73	31	28	3	24
1973-74	30	18	12	28
1974-75	41	15	26	32
1975-76	30	11	19	20
1976-77	13	8	5	1
1977-78	1	1	0	0
	167	100	67	119

As noted, the 167 claims listed above have resulted in 119 suits against participants in the program. Of these, 35 have been settled and 21 have been dismissed without indemnity payment. This leaves 63 outstanding at this time. During the past year only 20 suits have been registered or converted from outstanding claims.

A review of claims by specialty is as follows:

SPECIALTY	7-15-77—6-30-78	12-1-71—6-30-78
Anesthesia	6	22
Emergency	1	2
ENT	1	8
Gastroenterology	0	2
General Practice	1	5
General Surgery	5	41
Internal Medicine	2	6
Neurology	2	4
Neuro-Surgery	2	9
Ob-Gyn	3	26
Ophthalmology	0	2
Orthopedics	6	21
Pathology	0	1
Plastic Surgery	1	2
Psychiatry	1	5
Radiation Therapy	1	3
Radiology	2	4
Thoracic Surgery	1	2
Urology	1	2
	36	167

There have been no real changes in the Claim Review Panels or their locations but a total of 27 doctors have now participated either as panel members or case managers. Cooperation of all participants has been excellent and it is believed that all have benefited to some degree from exposure to the cases reviewed.

JAMES B. McCLEMENTS, M.D.
Chairman

(This report was filed.)

MATERNAL AND CHILD CARE COMMITTEE

The Committee for Maternal and Child Care met on August 29, 1978, at the Blue Coat Inn, Dover, Delaware.



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The stillbirth and neonatal mortality statistics for Kent and Sussex Counties for 1976 and 1977 were reviewed and are on file in the Medical Society office. The following observations were made:

1. The overall stillbirth and neonatal mortality rates have steadily decreased since 1973 for all three counties. (See Chart A)
2. Sussex County's rate still is higher than the other two counties. Reasons for this were discussed. The stillbirth and infant deaths were categorized as to unpreventable and preventable. (See Chart B)

The greatest number of neonatal deaths, as well as stillbirths, appears to be due to immaturity as a result of the onset of premature labor with or without premature rupture of the membranes. There did not appear to be much correlation between such factors as age of the mother, race, or whether the patient was a private or a clinic patient. Experience has shown that prenatal visits do not prevent prematurity. Recent studies tend to indicate that poor dietary practices may play some role and research is continuing along these lines.

It was noted that there are more indigent patients in Western Sussex County than in the Milford, Dover, or Lewes areas. At Nanticoke Memorial Hospital in Seaford 45% of all deliveries are "clinic" patients whereas in Milford (where there is no clinic) the private physicians have 10-15% indigent pa-

tients. In Milford an estimated one patient a month arrives in labor at the hospital without any prenatal care. Only three patients without any prenatal care were delivered in Seaford during 1977.

It was felt that the Wilmington Medical Center's lower rate resulted from:

1. Widespread fetal monitoring.
2. Prompt and more frequent cesarean sections.
3. The availability and proximity of an excellent Newborn ICU.
4. The continued presence of well-trained residents in both Obstetrics and Pediatrics.

After a thorough discussion of the problems of our smaller community hospitals, the Committee makes the following recommendations to improve maternal and neonatal health and health care:

- A. A liaison should be established between the Wilmington Medical Center and the downstate hospitals whereby:
 - A. Known high-risk patients could be seen at the Wilmington Medical Center as well as in their communities during their pregnancies. If possible these patients if problems arise could be delivered at the Medical Center, i.e. these babies could be transferred "in utero."
 - B. The system of transferring newborns in trouble to the Wilmington Medical Center Newborn ICU should be perfected.
 1. A Wilmington Medical Center pediatric

NEONATAL MORTALITY RATE

Chart A

	1972	1973	1974	1975	1976	1977
Kent						
Caucasian	8.59	8.41	7.45	5.80	4.20	2.38
Other	22.34	15.72	9.20	3.09	22.01	14.83
Total	11.59	9.96	7.82	5.23	7.96	5.01
# of births	1638	1506	1534	1529	1506	1595
New Castle						
Caucasian	10.60	9.86	8.71	6.56	6.89	7.68
Other	22.95	19.03	11.78	9.87	8.01	10.40
Total	13.08	11.68	9.32	7.21	7.12	8.22
# of births	5428	5051	5148	5129	5056	5350
Sussex						
Caucasian	10.07	14.58	18.25	18.30	10.61	8.77
Other	38.00	24.93	34.22	34.39	17.45	25.94
Total	19.75	18.18	23.81	23.89	12.98	14.73
# of births	1215	1155	1176	1172	1155	1222

of deaths 28 days or under per 1000 live births. National rate is 14.0.

Chart B-2

KENT AND SUSSEX COUNTIES

Unpreventable Neonatal Deaths 1976 and 1977

	Total: 30
Cord Complication before Labor	1
Placenta Abruptio	1
Congenital anomalies incompatible with life	8
Birth weight of less than 1000 Gm.	20

Possibly Preventable Neonatal Deaths 1976 and 1977

	Total: 23
Prolapsed cord during labor or delivery	2
Maternal Hypertension, (8 lb. 14 oz.)	1
Prematurity with Hyaline Membrane Disease or Respiratory Distress Syndrome	
Birth Weight 1000 Gm.-2500 Gm.	9
Prematurity 1000 Gm.-2500 Gm.	5
Septicemia, (5 lb.)	1
Meningitis, (7 lb. 5oz.)	1
Meconium Aspiration, (5 lb. 6 oz.) (8 lb.)	2
Pneumothorax, (5 lb. 8 oz.) (3 lb. 3 oz.)	2

resident could be brought down by helicopter, stabilize the patient and then return to the Wilmington Medical Center by helicopter, ambulance or by the special newborn van or

2. A "team" of residents from the Wilmington Medical Center could be available to go to the various community hospitals via helicopter.

C. Investigation of the possibility of rotating pediatric and obstetrical residents from the Wilmington Medical Center through the downstate hospitals on a definite schedule should be done.

D. Downstate physicians should be encouraged to take short courses or attend seminars at the Wilmington Medical Center to learn new techniques or refresh older ones.

Chart B-1

KENT AND SUSSEX COUNTIES

Unpreventable Intrauterine Deaths 1976 and 1977

Death before Labor	Total: 46
Intrauterine Anoxia	30
less than 1000 Gm.	9
1000-2500 Gm.	10
over 2500 Gm.	10
unspecified	1
Abruptio Placenta	5
less than 1000 Gm.	2
1000-2500 Gm.	2
over 2500 Gm.	1
Cord Defect	6
Growth Retardation	1
over 1000 Gm.	
Congenital Anomalies	4

Possibly Preventable Intrauterine Deaths
1976 and 1977

Total: 18	
Death before Labor	
Maternal Diabetes	2
(9 lb. 13 oz., 8 lb. 9 oz.)	
Death during Labor or Delivery	
Maternal Disease	
Hypertension	1
(4 lb. 12 oz.)	
Sickle Cell Anemia	1
5 lb. 13 oz.)	
Pre-eclampsia	1
Incompetent Cervix	2
Rh Sensitization	1
(2 lb. 1 oz.)	
Cord Problem during labor or delivery	4
Transverse lie neglected	1
Immaturity-Prematurity	5
1000-2500 Gm.	

E. Make the downstate physicians aware that genetic counseling is available at the Wilmington Medical Center.

- II. As prematurity-immaturity seems to be the leading cause of our neonatal deaths and stillbirths, a seminar on "the prevention and treatment of prematurity" should be given in Dover for obstetricians; pediatricians; family practitioners; and obstetrical, pediatric and clinic nurses.

This could be similar to Doctor Holloway's Annual Infectious Disease Seminar and could last several days. Perhaps the Delaware Obstetrical Society would sponsor it as well as the Medical Society of Delaware.

- III. Recognition of the high-risk maternity patient should be emphasized to the clinic nurses, and the widespread use of fetal monitoring and more prompt cesarean sections (if necessary) should be stressed to all. OB nurses might be trained to interpret the monitors, as residents aren't available in the smaller hospitals.

- IV. Last but far from least, pressure should be applied to the State Legislature to provide more funds to underwrite the care of indigent pregnant patients. The role of *preventive* health care should be stressed as opposed to the delivery of health care. (The Division of Public Health is receiving approximately the same funding as in 1972.)

JUDITH G. TOBIN, M.D.

Chairman

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(This report was filed. The House requested that in the future statistics on statewide abortions and maternal mortality be included and that all cases of maternal mortality be investigated at the hospital level.)

MEDICINE AND RELIGION COMMITTEE

The Medicine and Religion Committee has given its backing to and, while not being directly involved, wishes to recognize the development of chaplaincy programs at the downstate hospitals during the past year.

Pastoral care programs for nursing homes are also developing, but financing has slowed them considerably. I would like to recommend that the Medical Society of Delaware make a grant toward this very worthwhile program in the amount of \$500.

Plans for the annual prayer breakfast were made. It was decided to follow the format of the previous years and emphasize music as last year. It was also decided to recognize the chaplaincy programs in downstate hospitals by using physicians from these hospitals to read scriptures and inviting the Reverend Carl Sachtleben to report on this work.

HARVEY E. MAST, M.D.
Chairman

(This report was filed.)

MEDICO-LEGAL AFFAIRS COMMITTEE

The Medico-Legal Affairs Committee, as in the past, has functioned in an advisory capacity to physicians seeking information and guidance in medical-legal matters, which usually concern inter-personal and inter-professional relationships with attorneys, and occasionally with the legal interests of patients. Most of this activity was carried out informally by telephone, without a full meeting of the Committee, and left the distinct impression that the medical community is becoming much more sophisticated in medical-legal matters than it has been in the past.

The Committee met several times during the year. The following important subjects were considered:

1. The development of a policy concerning the release of patient information to industrial physicians. We are awaiting further correspondence from Doctor Bruce W. Karrh, President, Delaware Occupational Medical Association, with whom preliminary dialogue has begun. Development of these guidelines would greatly enhance the relationship between practitioners of occupational medicine and other doctors, and serve both the patients and the industrial community.
2. Support for the AMA position on marijuana legislation was expressed for proposed legislation that never came to a vote in the present legislature. The AMA position, in essence, feels that heavy criminal penalties are excessive, but

that in no sense can the use of marijuana be condoned.

3. Additional, but rather minor steps have been taken in an attempt to develop community standards for consent forms. The obvious hazards of doing this without full regard for the implications necessitates cautious and slow movement in this sensitive area.
4. Guidelines for fees for medical-legal services provided at the request of attorneys, particularly for court appearances that are subject to late cancellation, were established. These guidelines are available through the Society for those physicians who need to refer to them.
5. The Chairman of the Medico-Legal Affairs Committee has also worked on the Study Commission on Malpractice Legislation. This Commission is currently reviewing the portion of the legislation that requires that experts testifying in malpractice actions need be "familiar" with Delaware practice. Some attorneys consider this to be too restrictive. A judicial decision on an appealed case has recently been rendered; a copy is on file in the Society office.

Although not within the Committee's direct purview, the review panel constituted under the present malpractice review statute has been functioning, and few complaints about its activities, from either the medical or legal sides, have come to the Committee's attention.

MARTIN GIBBS, M.D.
Chairman

THE MENTAL HEALTH, ALCOHOLISM, AND DRUG ABUSE COMMITTEE

The Mental Health, Alcoholism, and Drug Abuse Committee had a very successful seminar on 13 November 1977 on Violence in the Family.

Since then we have held three meetings at which the Committee has discussed the importance of psychiatric representation on HSA and SHCC, the status of the Committee for the Impaired Physician, and the forming of an ad hoc committee with the Delaware Pharmaceutical Society to discuss the amphetamine problem and the use and abuse of amphetamines in the State.

RICHARD WINKELMAYER, M.D.
Chairman

SCHOOL HEALTH COMMITTEE

Most of the energy and time of this Committee have been devoted to recognizing the problems that are raised from the point of view of school health services and education in the consolidation of the 11 school districts of New Castle County into one school district. There were significant differences in patient services, particularly in the Wilmington District vs most of the suburban ones, which needed to be resolved. While the problems have not all been solved,

the Committee did receive permission from the Board of Trustees to discuss these with the representatives of the new administrative staff of the new school district. Specific recommendations were made, and the general outline of program development, which the administrative staff proposed, was reviewed and critiqued. The representatives of the Committee met with Dr. Kirk, the Administrative Superintendent in charge of this portion of the program, and he agreed there was a need for a health advisory committee for the District to which the chairman of this Committee has been nominated by the State Medical Society, after Dr. Biggs formally requested the Society appoint such a nominee. Dr. Kirk outlined the limitations under which they were working: (1) they could not expand personnel, which the basic program that we had reviewed would have demanded; and (2) implementing the program would take a period of time with an active advisory committee, with which the new Board of Education would be interested in working. So, it is hoped that at least initial steps have been made to see that health problems and health education are not forgotten in the consolidation and that, if possible, this will be used as an opportunity to improve the quality, if not the quantity, of services and health education. This may be easier to do with central planning. There is also some hope that some of the budgetary squeeze may be ameliorated by some of the Federal programs, which are now becoming operative in this field.

The Committee has continued its liaison with the School Health Advisory Committee of the State of Delaware. For the time being, chiropractic recognition for professional purposes by the schools has been ruled by the Attorney General's office not to be acceptable.

One of the new task forces being set up by the Statewide Health Coordinating Council and the Delaware Health Council is related to preventive care and health education. The Chairman of the School Health Committee is a member of this task force. Hopefully, keeping lines of communication open in this way will enhance the work and effectiveness of the physicians in the field of school health.

There has been some conflict with the Academy of Pediatrics, which was due to poor communication, which we have attempted to resolve at the Committee level.

The Committee looks to the future as a real challenge and would remind the Medical Society that, in the area of school health, its activities may not only benefit the students of the State but also serve to emphasize the Society's interest in health education and preventive care.

ROBERT W. FRELICK, M.D.
Chairman

(This report was filed.)

NOMINATING COMMITTEE

A meeting of the Nominating Committee was held at the Delaware Academy of Medicine on August 3, 1978 to consider positions to be filled for the year September 1978 through 1979.

The following nominations were made:

Vice-President—Leslie W. Whitney, M.D.

Secretary — Joseph E. Belgrade, M.D.

Treasurer—Peter R. Coggins, M.D.

Representative to the Delaware

Academy of Medicine—Joseph W. Abbiss, M.D.

FOR STANDING COMMITTEES

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Thomas R. Brooks, M.D.

Thomas E. Dyer, M.D.

George R. Hilty, III, M.D.

Thomas S. Vates, Jr., M.D.

Howard Wilk, M.D.

Bylaws Committee

Daniel A. Alvarez, M.D.

Rhoslyn J. Bishoff, M.D.

Norman L. Cannon, M.D.

John J. Egan, M.D.

Robert B. Flinn, MD

C. E. Graybeal, M.D.

Christos S. Papastavros, M.D.

Dene T. Walters, M.D.

Medical Economics Committee

Olin S. Allen, II, M.D.

Robert T. Beattie, M.D.

Ben C. Corballis, M.D.

Conley L. Edwards, M.D.

Joseph A. Elliott, M.D.

Warren R. Johnson, M.D.

William D. Johnson, M.D.

Douglas W. MacKelcan, M.D.

Robert L. Meckelnburg, M.D.

Carl P. Mulveny, M.D.

Bhaskar S. Palekar, M.D.

Jae K. Park, M.D.

Emanuel M. Renzi, M.D.

Robert Scacheri, M.D.

Donald Schetman, M.D.

Howard Wilk, M.D.

Medical Review Committee

Joseph M. Barsky, Jr., M.D.

Joseph E. Belgrade, M.D.

John H. Bengé, M.D.

Jason L. Campbell, M.D.

I. Favel Chavin, M.D.

James Dearworth, M.D.

Charles A. Depfer, D.O.

Thomas E. Dyer, M.D.

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Robert W. Frellick, M.D.

C. E. Graybeal, M.D.

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Calvin B. Hearne, M.D.
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Edmund Scott, D.O.
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Charles Smith, M.D.

Ignatius J. Tikellis, M.D.
Thomas S. Vates, Jr., M.D.

Incoming Presidents, Kent and Sussex County Medical Societies

Medical Services Insurance Committee

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Joseph E. Belgrade, M.D.
John H. Bengé, M.D.
Jason L. Campbell, M.D.
I. Favel Chavin, M.D.

James Dearworth, M.D.
Charles A. Depfer, D.O.
Thomas E. Dyer, M.D.
John J. Egan, M.D.

Robert B. Flinn, M.D.
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Program Committee

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Bernadine Z. Paulshock, M.D.
Eleonora F. Schneider, M.D.
Charles Smith, M.D.

Public Laws Committee

Robert Abel, Jr., M.D.
Charles Allen, M.D.
Rhoslyn J. Bishoff, M.D.
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Edward F. Gliwa, M.D.
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**REPORTS OF
LIAISONS AND REPRESENTATIVES**

**AMERICAN CANCER SOCIETY
DELAWARE DIVISION, INC.**

Professional Education Committee

The primary aim of the professional education program of the American Cancer Society, Delaware

Division, Inc. is to inform professionals about the best possible cancer detection and management techniques and to encourage the use thereof. To this end, the Professional Education Committee has: 1. financially supported continuing education seminars, grants, and travel to selected national and out-of-state conferences; 2. planned educational conferences; 3. distributed educational literature; 4. loaned films, slides, and audio-tapes; 5. provided speakers for meetings of professional groups.

The scientific program on immunology and immunotherapy, presented at the 188th Annual Meeting of the Medical Society of Delaware, was supported by ACS in the amount of \$500. In addition, \$200 was allocated for our continuing education seminars on cancer for physicians.

An \$8,000 ACS professional education grant was awarded to the School of Life and Health Sciences, University of Delaware. The purpose of this grant is to strengthen the foundations of teaching and research programs of Dr. Daniel T. Simmons, a viral oncologist, and Dr. David C. Usher, an immunogeneticist.

In a further effort to support educational endeavors at Kent General Hospital, the ACS supplied \$1,950 for the purchase of an Olympus LS-2 Lecturescope.

Funds will again be provided for a medical student work/study program at Kent General Hospital. In fulfillment of the requirements of this program, this past year the recipient of the \$500 grant, Ms. Patricia Fitzpatrick, prepared a paper entitled, "Colorectal Cancer at Kent General Hospital 1972-1976." It will be published in the *Delaware Medical Journal*.

Margaret A. Willey, cytotechnologist in the State Public Health Laboratory, was given \$412 for educational expenses of the 25th Annual Scientific Meeting of the American Society of Cytology held in Toronto in November.

M. Pearla Tabangin, clinical dietician at the General Division, was funded to travel to the ACS-NCI National Conference on Nutrition and Cancer held in Seattle, Washington, in June.

The Professional Education Committee has reaffirmed the policy of sending complimentary copies of the bi-monthly ACS publication, *Ca-A Cancer Journal for Clinicians*, to interested physicians. In addition, three new films and three new audio-tapes have been purchased for use in continuing education.

The aim of the professional education program can only be realized with the support and assistance of professional volunteers. Appreciation is extended to all volunteers who made this year's program possible.

Service and Rehabilitation Committee

Although the Society's resources do not permit the payment of hospitalization, doctor bills, and radiation therapy, the ACS is able to offer some type of assistance to almost every cancer patient who con-

tacts us. This year, the total number of patients served was 687.

Services offered by the Society include assistance and information, rehabilitation groups such as the Reach to Recovery group for women who have had breast cancer, the laryngectomy program, and the ostomy rehabilitation groups. Loan closet items such as beds, crutches, walkers, wheelchairs, bedpans, etc., are available through the ACS offices in Wilmington, Newark, Dover, and Georgetown.

"21 Answers to the Most Commonly Asked Questions about Chemotherapy," an informative brochure, was developed with the cooperation of the Service Committee, Public Information Committee, and much assistance from Carpenter Clinic. The pamphlet has had a high number of requests from doctors and allied health professionals. Another brochure, "Please Call Us," outlines the services provided by ACS in Delaware. Both brochures are available upon request.

Public Information Committee

The Public Information Committee reports Cancer Society information to community newspapers, magazines, radio stations, and two television stations (WHYY-TV and Rollins Cablevision). The Committee is responsible for publishing the annual report and three newsletters.

The movie, "When the Blues Are Running," a project begun in 1976, was premiered on December 7, 1977 at the Academy of Medicine. Over 150 people attended, and the requests from organizations and allied health professionals, both inside and outside the State, have been overwhelming. The film was written and directed by Arden Films Company and was originally made for the lay public. The story follows a cancer patient and his family and focuses on the value of the interdisciplinary team approach in the care of the cancer patient.

"When the Blues Are Running" has been submitted for honors to the National ACS, the 10th Annual Public Relations Film Festival, and the CINE Film Festival.

Public Education Committee

Colorectal cancer education programs were conducted for adults in business and industry. Approximately 17,000 adults have been reached this year with life-saving information on lung, colorectal, breast, and uterine cancer.

Since last year, activities on smoking and health have increased approximately 400% nationwide. Locally, "stop smoking" programs continue to be implemented throughout the community. "I QUIT KIT," a self-help program designed to help smokers quit, has been distributed to some 300 Delawareans.

ROBERT L. MECKELNBURG, M.D.
Liaison

(This report was filed.)

AMERICAN DIABETES ASSOCIATION DELAWARE AFFILIATE, INC.

I am pleased to report that during the past 12 months the American Diabetes Association, Delaware Affiliate, Inc. has experienced many beneficial and progressive changes.

The addition of Executive Director David B. La Vallee enabled the Affiliate to realize this administration's original goals of increased membership and improved earning power.

The relocation of our operations to newer and larger quarters, as well as the opening of our office on a full-time basis, significantly increased our ability to better serve the general public and our ever-growing membership.

Our revised newsletter, *Diabetes Digest*, has developed into a more effective publication, generating increased mailing and greater awareness of our expanding Statewide activities.

All of these factors, in combination with a greater number of volunteer workers, considerably improved our earning power and resulted in increased revenue.

Our continued, wholehearted support of dedicated staff members and volunteers will insure the consistent improvement and expansion of the Affiliate's education and detection programs for the general well-being of all Delawareans.

HOWARD Z. BORIN, M.D.
Liaison

(This report was filed.)

ARTHRITIS FOUNDATION DELAWARE CHAPTER

The Chapter during 1978 has kept the lay and professional community informed of the many local and national activities in the field of rheumatology. The Chapter also continues the semi-monthly consultative work at the Milford Memorial Hospital. The Foundation has just made a rheumatology nurse specialist available to the patients at the Arthritis Clinic at the Memorial Division of the Wilmington Medical Center; her function will be to teach and counsel the patients on the management of their disease.

During the year 270 patients were referred to doctors, clinics, and/or treatment centers. Volunteers from the Chapter participated in 12 public exhibits and over 50 program presentations, distributing over 20,000 pieces of literature.

As a part of its scientific program the Chapter will sponsor a symposium on "The Comprehensive Management of Arthritis" on the 15th and 16th of September 1978.

ALLEN C. WOODEN, M.D.
Liaison

(This report was filed.)

AUTOMOTIVE SAFETY

The Society had little involvement or activity with automotive safety during the past year.

Primarily we were concerned with correspondence and literature in reference to highway safety, accident prevention, seat belts, driving and drinking, teenage driving and drinking, alcohol in general, and bicycle riding with movies and brochures in reference to all of these activities.

It was my feeling that the Medical Society should not become involved in purchasing movies in reference to driving education as State facilities have monies appropriated for these materials that are readily available to the high schools and other organizations.

The Society was opposed to the repeal of the protective helmet law for motorcyclists, but the General Assembly did repeal the law.

DAVID L. SCHAFER, M.D.
Representative

(This report was filed. The House of Delegates directed that the Society make its feelings known to the Legislature and the Governor's office that we continue to oppose liberalization of the helmet law for motorcyclists.)

COMMUNITY COUNCIL ON EMERGENCY SERVICES

For the past two years, the role of Representative to the Community Council on Emergency Services has been, in essence, the Chairmanship of the Delaware Emergency Medical Services Advisory Council. This dual role is most fitting since DEMSAC (established by the Legislature with its Chairman appointed by the Governor) acts in a supervisory and advisory capacity to the Office of Emergency Health Services of the Department of Health and Social Services of the State of Delaware. As such, it is deeply involved in the preparation and administration of the Grant Fund awarded for the development of an Emergency Medical Services System through the Department of Health, Education and Welfare.

Fiscal 1977-78 has seen great progress in the development of the Emergency Medical Services System here in Delaware. During this period of time we carried out the first year of the development of a Basic Life Support System throughout the State. The activities undertaken included training of first responders (police, fire, and other public agency personnel) in CPR. It also saw the beginning of CPR training in high schools throughout the State and instruction in basic emergency measures beginning in kindergarten and eventually extending throughout the entire primary school system. Funds were used to continue the Wilmington Medical Center Paramedics Training School so as to enable this vital service to continue. Much needed medical equipment was purchased for the Newark Emergency Room and the City of Dover. Probably the highlight of last

year's program was the acquisition and installation in every emergency facility in the State of Delaware of a videotape player and TV receiver with a specially designed stand which enables it to function as a unit for education purposes.

In conjunction with the State Emergency Health Office, DEMSAC has purchased a library of videotapes to be used for the training of EMT's, emergency room nurses, and emergency room physicians.

During this same year, the Emergency Medical Service Councils in each of the three counties were revitalized with Sussex and New Castle being the most active. Their most important function has been to assist in the development of the Statewide Emergency Communication Network, which is being purchased through funds made available by the Department of Transportation. During this past year in Sussex County, equipment was purchased which enables direct radio communication between ambulances, hospitals, and dispatch centers on specially designated frequencies reserved by the FCC for medical purposes. During the next two years, this network will be installed in Kent and New Castle Counties. When it is completed, there will be complete direct voice and telemetry communication between all ambulances and hospitals in the State of Delaware. It will also be possible to interconnect all agencies involved in disaster planning and disaster work, should that ever be necessary. We feel that the development of this network will foster a great deal of close cooperation between emergency physicians, nurses, and EMT's leading to a far greater level of care delivered to the patients both at the scene of accident or illness and during transport to an emergency facility.

The Medical Society is aware of the difficulties facing the paramedic program in New Castle County, and all of us involved are deeply appreciative of the support received from the Society at a critical period of time. During the coming year, we hope to preserve and expand the paramedic program throughout all of New Castle County and have already committed ourselves to the training of ambulance attendants employed by the City of Dover to the paramedic level. While no formal arrangements have been made, we have had several applications from individuals in Sussex County desirous of being trained to the paramedic level as well.

I would like to pay tribute to the very dedicated and involved physicians, nurses, and ambulance attendants who have worked so hard to make this a very positive year in Emergency Medical Services throughout the State of Delaware. Their efforts have resulted in the State receiving an award of \$219,000 from HEW for fiscal 1978-79 to complete the development of the Basic Life Support System throughout the state and to begin planning for the first year of an Advanced Life Support System installation.

HOWARD A. LOVETT, JR., M.D.
(This report was filed.) *Representative*

CONTROLLED SUBSTANCES ACT ADVISORY COMMITTEE

The Controlled Substances Act Advisory Committee had meetings on October 13, 1977; November 23, 1977; January 11, 1978; February 22, 1978; and April 19, 1978. These meetings took place in either the Jesse S. Cooper Building in Dover or the Office of the State Medical Examiner at 200 S. Adams Street in Wilmington.

Two subjects were studied by the committee in all of those meetings: the scheduling of two drugs, phentermine and pentazocine, and the advisability of applying for a grant from the DEA (Federal Drug Enforcement Administration) to start a Drug Investigation Unit (DIV).

Delaware already has, in place, a weak Drug Investigation Unit, which has no such name and is the result of cooperation across concerned people in the pharmaceutical, judicial, medical, and law enforcement groups of our State. Interviews of John Sauer and Tom Crowe of DEA out of Washington, D.C., revealed that were we to apply for such a grant no assurance could be made that the cost factor would not be a later drag on the State's Budget. Evidently, Washington saw the error in doing such work with a small state that had a workable, albeit weak, operation already in place and the grant offer was withdrawn.

At the October 13, 1977 meeting the placement of phentermine (Ionamin) as a Schedule IV Controlled Substance was announced.

Pentazocine (Talwin) was given hearings to be considered a Scheduled Drug. Testimony was heard from David A. Levitsky, M.D., President of the State of Delaware Board of Medical Practice, Robert T. Beattie, M.D., representing himself, Janet Kramer, M.D. representing herself, Mr. Roger Rodwin, an attorney representing Winthrop Laboratories, and their Medical Director Robert Speer, M.D., and William Martin, M.D., considered to be an expert and unbiased witness on the subject of pentazocine.

At its most recent meeting on April 19, 1978 the committee reviewed all verbal evidence presented on pentazocine as well as volumes of documents received on the subject. After much discussion a vote was confirmed that recommended to Dr. Barbara Rose that Talwin be placed on the Schedule as a Class IV drug. (This means Talwin (pentazocine) is now a reportable drug in our State.)

Further suggestions were made to alert physicians and pharmacists to avoid or be cautious of the patient requesting or receiving both Pyribenzamine and pentazocine.

No further meetings were planned, but it was understood that meetings would be called as the need arises.

RHOSLYN J. BISHOFF, M.D.
Representative

(This report was filed.)

COORDINATING COUNCIL FOR THE HANDICAPPED CHILD INCORPORATED

I should like to report as Liaison to the Coordinating Council for the Handicapped Child Incorporated from the Medical Society of Delaware for the 1977-78 year.

I have attended all Executive Committee meetings held every other month at the Alfred I. duPont Institute.

During the year the Coordinating Council made an effort to assess its course in the State of Delaware. During this period a Needs Assessment Survey was made of each agency making up the Coordinating Council. It was determined that the needs for the handicapped were in six categories: 1. funding; 2. staffing; 3. vocational education programming; 4. facilities for alternative living; 5. training for pre-program and in-service; and 6. staff roles.

As the result of the Needs Assessment Survey, a fall program to consider alternative living arrangements for the handicapped child and adult will be held September 16, 1978, at the Alfred I. duPont Institute. This meeting will be open to all persons who are interested in living arrangements for the handicapped.

Ms. Doris LeSturgeon, Principal of Pilot School, has been elected chairman of the Coordinating Council for the Handicapped Child Incorporated for the year of 1978-79.

I hope this information on my services as Liaison to the Coordinating Council for the Handicapped Child will be helpful.

HENRY H. STROUD, M.D.
Liaison

DELAWARE HEART ASSOCIATION

Effective July 1, 1978, the name of the Delaware Heart Association has been changed to American Heart Association of Delaware.

The Heart Association channels its efforts in three major areas—research, education, and service. There are relatively few Delaware-based research requests, and during fiscal 1977-78 the Heart Association funded \$12,500 in local projects and \$26,000 nationally. For 1978-79 this will be up slightly to \$17,840 locally and \$27,000 nationally.

Much of the educational effort was directed at the general public since it appears that lack of knowledge by the public is one of the chief obstacles to further reduction in incidence and mortality. Efforts were also directed at physicians' education and the education of nurses and other health personnel. *Modern Concepts of Cardiovascular Disease* and *Current Concepts of Cerebrovascular Disease (Stroke)* are both mailed regularly to interested physicians. The David Flett duPont lecture given annually at the Delaware Academy of Medicine is sponsored by the Heart Association, and this year

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Dr. William P. Castelli was the guest lecturer on the topic "High Density Lipoproteins."

The programs or services of the Heart Association have focused for the most part on three undertakings. The first of these, blood pressure screening, is gradually being reduced. The second, basic life support or cardiopulmonary resuscitation, is being expanded. Programs in advanced cardiac life support have been conducted for providers of care and for instructors for future courses. We now have core faculty in Delaware that can teach advanced cardiac life support, and therefore we can conduct further programs without going outside of the State for assistance. The third major effort is the special ambulance evacuation service which until now has been concentrated in the city of Wilmington. Efforts are being made to expand this service to other areas in New Castle County and to tie it in with private voluntary ambulance services.

Finally, it should be noted that the Heart Association has become increasingly more active in Kent and Sussex Counties. The next president will be from Dover.

E. WAYNE MARTZ, M.D.
Liaison

**DELAWARE INSTITUTE FOR MEDICAL
EDUCATION AND RESEARCH
DIMER 1977-78**

As of July 1, 1977, the State of Delaware discontinued all support of the Medical Education Program at the Wilmington Medical Center and of the Health Sciences Program at the University of Delaware. A total of \$850,000 was appropriated to pay the Jefferson subvention and provide some scholarship funds for needy students. This was subsequently reduced by 1%, and since the Jefferson subvention was fixed at \$800,000, the amount available for student assistance had to bear the entire cut and became \$41,500.

The Wilmington Medical Center responded to this loss of support the only way it could, namely by passing the cost through to paying patients and their third party insurance carriers. The total cost of the program was reduced as much as could be consistent with continuance of a quality educational experience. The University of Delaware responded to the loss of DIMER funds by an internal reallocation of funds, resulting in some sharp reductions in other departments.

A full budget was again requested in October, 1977, for July 1, 1978, but by February it became very apparent that funding would remain the same. The Board of Trustees continued to meet at regular intervals, and minutes of these meetings have been sent to the Medical Society of Delaware where they are available for inspection by any interested persons.

A full class of 20 Delaware applicants was admitted to Jefferson September, 1977, and a full class of 20 has been selected for admission September, 1978. Twenty-one Delawareans completed their

studies at Jefferson and were graduated June, 1978.

LESLIE W. WHITNEY, M.D.
President, Board of Trustees
DIMER

(This report was filed.)

**DELAWARE INTERAGENCY COUNCIL
ON SMOKING AND HEALTH**

During the past year the Interagency Council held three meetings. Two new organizations joined the Council: Blue Cross/Blue Shield and Delaware League for Planned Parenthood.

Activities undertaken during the year included the formation of a committee and the gathering of materials for the preparation of the comprehensive health curriculum guide for grades K through 4.

The Council also participated in the Governor's Health Week in Delaware, which coincided with National Education Week on Smoking, January 8-14, 1978. An exhibit on smoking was circulated to each county during the week with member agencies manning the booth and supplying handout materials. The Council also had a representative present in Washington during National Education Week on Smoking when HEW Secretary Joseph Califano launched the government's new and intensified drive against cigarette smoking.

Local legislation continued to receive our interest and support. Specifically, the Council endorsed new legislation prepared by Representative Gwynne Smith, which would protect the rights of non-smokers in public places in Delaware. Also receiving Council support was legislation to prohibit smoking by any person on public or private school property in this State. Neither bill has been enacted.

Individual member agencies of the Council continue to be actively involved in various facets of the anti-smoking programs. Areas of program concentration include educating the very young child, statewide clinics for persons who wish to break the habit, and supplying various resources and scientific information on the rights of the non-smoker campaign.

In conclusion, it is noteworthy to mention that many physician and dental offices in our state are becoming no-smoking areas and rightly so. Council members are increasingly being called upon to supply no-smoking signs, buttons, and literature for these facilities.

ROBERT ALTSCHULER, M.D.
Liaison

(This report was filed.)

DELAWARE LUNG ASSOCIATION

The past year has continued to be an active one for the Delaware Lung Association in its programming endeavors. The Association became involved in some new programming areas and also continued others which have proven worthwhile.

PROJECT A.I.R.S.—The Air Index Reporting System, which provides meaningful air quality and effects information for the citizens of Delaware, celebrated its second year in October 1977. The air quality data in Delaware is given on a daily basis to WNRK, WDEL, and WHYY-TV.

DELAWAREANS FOR ENERGY CONSERVATION—The Association has continued to work actively with this group and in March co-sponsored an Energy/Solar Fair with this group and the State Energy Office. An estimated 1,000 persons attended to hear Governor duPont speak, participate in panel discussions, and view over 25 exhibits.

ASTHMA PROGRAMMING—An Asthma Workshop was held in April at Delaware Technical and Community College—Stanton Campus for families with an asthmatic child. The workshop was conducted by Robert Lang, A.R.R.T., of the Wilmington Medical Center.

PHYSICIAN SEMINARS—Again this year the Association supported the Medical Society of Delaware's continuing medical education seminars for physicians by sponsoring two programs related to respiratory diseases, care, and prevention.

INFECTIOUS DISEASE SYMPOSIUM—The Association also continued to support this annual symposium held in May in Rehoboth and Wilmington for Delaware physicians and other interested persons.

HEALTH FAIRS—During the past year we were called on to participate in a total of seven health fairs throughout the State, all designed to promote personal and preventive health care. Pulmonary function screening tests were offered at a number of these events.

PULMONARY FUNCTION—The three-year-old pulmonary function screening program continues to be offered as a community service. Nearly 4,000 persons were tested in 1977 at the Association's offices, industrial sites, schools, and public locations.

CHEST X-RAYS AND SKIN TESTING—The Lung Association continues to provide this valuable service to thousands of people each year on a doctor's referral. TB skin testing is available to the public also at our offices.

PUBLICATIONS—The Association continued to provide subscriptions of *Basics of R.D.* to resident and intern physicians, student nurses, and inhalation therapy students in Delaware. Interested Delaware physicians also continued to receive subscriptions to *Clinical Notes on R.D.* New copies of the book, *Lung Disease, State of the Art—1975-76*, were presented to St. Francis Hospital, the Wilmington Medical Center, and the Academy of Medicine medical libraries. Three new slide/tape programs were selected and presented to the College of Nursing, University of Delaware.

SCHOLARSHIPS AND GRANTS—Tuition assistance was provided for two staff members from Nanticoke Hospital to attend a Workshop in Respira-

tory Intensive Care at Hahnemann Medical College, October 10-21, 1977. Scholarship support of the Delaware Technical and Community College Inhalation Therapy program was continued by providing assistance to a technician in training from Kent General Hospital. The Association also sponsored attendance of two respiratory therapists from the Wilmington Medical Center at the Annual Meeting of the Delaware Valley Chapter, American Association of Respiratory Therapists in Philadelphia, March, 1978.

PUBLIC HEALTH EDUCATION AND COMMUNITY SERVICES—January, 1978 found DLA participating, along with many other public, private, and state agencies, in a new program for Delawareans known as "Governor's Health Week." The purpose of the week was to promote better health among Delawareans; the Association was involved in some of the later planning of the event and supported it in several ways, including exhibits and pulmonary function testing in all three counties. In April we participated in the annual statewide PTA Convention with an exhibit and pertinent handout materials for parents. An in-service program for the aides at Geriatric Services on respiratory diseases, including a film presentation and talk by an instructor from the Nursing School of Wilmington, is an example of a number of programs presented to similar industrial, social, and school groups throughout the year in an effort to prevent and control lung disease.

JAMES M. HOFFORD, M.D.
Liaison

(This report was filed.)

DIVISION OF VOCATIONAL REHABILITATION STATE OF DELAWARE

Over the past year, there has actually been no formal liaison between the Division of Vocational Rehabilitation and the Medical Society of Delaware, and I am recommending that this liaison be discontinued on a formal basis. I continue to have personal contact with the Division of Vocational Rehabilitation through inpatients at the Eugene duPont Hospital and am recommending continuation of that, but I do recommend the discontinuation of the formal liaison and, further, the discontinuation of these annual reports.

ANTHONY L. CUCUZZELLA, M.D.
Liaison

(This report was filed.)

MEDICAL ADVISORY COMMITTEE, DIVISION OF SOCIAL SERVICES, STATE OF DELAWARE

This year the Blue Cross-Blue Shield contract for Medicaid was sought and won by The Computer Company. We must now hope TCC (The Computer Company) will, in some measure, make up for some of the losses that have occurred with the change of third-party payors. As always seems to happen

when poorly informed public officials seek new contracts, the low bidder always increases someone's costs. We always get only that for which we pay. In this instance, the pharmacists lost their sight draft payment, their contract, and their faith in a tenuous trust that had been developed between the pharmacists and the Division of Social Services through their mutual understanding as members of this committee, the Medical Advisory Committee.

We physicians have also lost. We are to have our Medicaid payments delayed by TCC until we can give TCC proof that we have first been paid for coinciding services by Medicare. (This was a service performed completely by the Blues in the past and will now require two sets of paper and two mailings for the same service.)*

What will or can this new agency, TCC, do to compensate for these previously mentioned losses to pharmacists and physicians?*

The Medical Advisory Committee strengthened its consumer image by first listening to the Rev. James M. Young of the Methodist Action Program and then inviting his organization to join and be a contributor to the deliberations of this Committee.

Clinical psychologists through their organization, the Delaware Psychological Association, have bid to be considered as providers of Medicaid services. They are seeking to have a schedule of payments for their services as a part of the State of Delaware's Medicaid Budget. Their brief will be heard on the third Wednesday of September. The psychologists are the second group to apply for this attention from the Division of Social Services in the last fifteen months; the earlier group was the chiropractors.

Elections held in December 1977 returned the following representation for the succeeding two years: Medical Society of Delaware

Rhoslyn Bishoff, M.D.

Robert Abel, M.D.

Anne Shane Bader, Alternate

Delaware Chapter, American Academy of Pediatrics

David Levitsky, M.D.

Division of Public Health

Frank Shannon, M.D.

Delaware State Osteopathic Medical Society

A. A. Golden, D.O.

Delaware State Dental Society

Terry A. Bryan, D.D.S.

Delaware Optometric Society

H. Martin Moss, O.D.

Delaware Pharmaceutical Society

Mr. Mark Abrams

Division of Mental Health

Mr. Dale Bunting

Visiting Nurses Association

Mrs. Dorris Schwartz

*The Blues, it would appear, honestly tried to keep the individual physician's costs down and were given no cash reserve to provide immediate payment; nor were they supplied with accurate identification lists.

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Blue Cross-Blue Shield

Mr. Patrick Coffey

Wilmington Public Schools

Mrs. Sherita Mahoney

Association of Delaware Hospitals

Mr. James P. Tyler

Delaware Health Council

Mr. Robert Tremain

Consumers

Ms. Pam Heydt—Sussex County

Ms. Jean Colon—Kent County

A. R. Lieberman—New Castle County

The nominating committee also recommended the re-election of Drs. Rhoslyn Bishoff, Chairman, and H. Martin Moss, Vice-Chairman.

ROBERT ABEL, JR., M.D.

RHOSLYN J. BISHOFF, M.D.

Representatives

(This report was filed.)

SPINA BIFIDA ASSOCIATION OF DELAWARE

Although great emphasis has been placed on providing services for handicapped children, the Spina Bifida Association of Delaware (SBAD) along with the national organization has begun to focus attention on the preventive measures, namely pre-natal testing. The development of Alpha Feta Protein (AFP) screening to detect the birth defect spina

bifida has caused great concern among the medical profession, citizens, and religious groups. Since this simple blood test makes it possible for pregnant women to determine for themselves if they want the responsibility of giving birth to a handicapped child, SBAD, along with the national organization, has adopted the following positions:

- * Screening shall be available to all pregnant women, but participation is voluntary.
- * The mother should be provided with educational material which presents both the treatment and abortion alternatives to allow her to be an informed participant.
- * The results, if positive, shall be presented as information for the parental decision-making process.
- * No formal stand should be taken on the abortion issue since a decision to undergo abortion is a personal decision made after considering all of the complex issues involved and options available.

On the local level, many of our children may be adversely affected by the desegregation situation. Several spina bifida children are participating in successful mainstreaming programs (attending some classes with non-handicapped children), which may be jeopardized by forced busing. Most of the programs are held in physically accessible schools accompanied by appropriate support services (therapy, resource rooms, medical services, etc.). If the class the child attends is bused to another school, what happens if the school is not accessible to the physically handicapped? Will the special services follow the child?

SBAD is a charter member of the Ad Hoc Coalition for Exceptional Children of New Castle County, a group of parents and concerned citizens dedicated to promoting the educational needs and general welfare of exceptional children and adults. The Coalition is trying to make elected and school officials

aware of the unique needs of the handicapped and to ensure that these needs are met.

We have not achieved as much success as we had hoped with our parent outreach program. We have parents who are trained to deal with the trauma of the birth of a handicapped child and who can offer help and information to the family.

All health professionals are urged to encourage their patients to seek the assistance that is available to them. No forms or lengthy reports are needed. A simple phone call to 478-5869 will put the patient in touch with someone who can help.

The 1979 National Convention will be held in Washington, D.C. from April 18-22. SBAD is planning to send as many people as possible to the convention and welcomes the support and participation of the entire Delaware medical community.

More information on the Spina Bifida Association of Delaware is available from the President, Ed Ziegler, at 731-9120.

NINA L. STEG, M.D.
Liaison

As a memorial to the members of the Society who were lost through death during the past year, the assembly rose for a moment of silence as the names were read:

Karnik Gurdikian, M.D.
James B. Homan, M.D.
Gordon Keppel, M.D.
Nizar Kuseybi, M.D.
Daniel J. Preston, M.D.
Norman L. Yood, M.D.

(Resolutions considered at the House of Delegates Meeting will be published in the January 1979 issue of the *Delaware Medical Journal*.)

(The complete report of the Proceedings of the House of Delegates is on file in the Medical Society office and is available to members for reference.)

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Book Reviews

THE HORIZONS OF HEALTH edited by Henry Wechsler, Joel Gurin, George F. Cahill, Jr., Harvard University Press, Cambridge, Massachusetts, 1977. 412 pp. Illus. Price \$15.00.

A century ago medical research was a relatively simple process, usually done by a scientist working alone in a small laboratory with very modest equipment. Increasing complexity of biomedical knowledge in the 20th century and the development of refined research techniques requiring very expensive tools have resulted in a multibillion dollar enterprise, competing for a large segment of our nation's financial resources. Co-editors Henry Wechsler, director of research for the Medical Foundation, Inc. of Boston, Joel Gurin, science writer and contributing editor of *Harvard Magazine*, and George Cahill, Jr., M.D., director of research at the Joslin Diabetes Foundation, state: "Nearly three billion dollars of federal money is now spent on medical research every year; and while this is only 10% of the annual federal budget for health, it is still a sizeable sum." Privately supported research consumes millions more from donations and endowments.

The authors do not deny the need for continued research in such major medical problems as cardiovascular disease, cancer, mental illness, genetic disorders, and many other conditions which result in infant and adult mortality or disability, eg, prematurity and dental disorders. The theme of this book, however, is that resources for research should be allocated rationally, not politically. This involves many considerations including statistical, social, and moral factors.

Contributing authorities such as John Merrill, M.D., Louis Weinstein, M.D., and others from Harvard, Hugo W. Moser, M.D., from Johns Hopkins and Donald Frederickson, M.D., director of N.I.H., present recent developments in their fields of medicine and biomedical research

with thoughts regarding future directions. This results in an over-all view of the status of medical science today and the prospects for tomorrow that should be of interest to the general public, practitioners of medicine, researchers, sociologists and health planners. Doctors who want to know what is going on outside their own specialties will enjoy reading this book.

ROBERT L. WURTZ, M.D.



ANOTHER KIND OF AUTUMN by Loren Eiseley, Charles Scribner's Sons, New York, 1977. 95 pp. Illus. Price \$8.95.

For years I have been a devotee of the books of Loren Eiseley, the late professor of anthropology and philosophy at the University of Pennsylvania. The two disciplines combined remarkably in the person of Dr. Eiseley. Even his scientific works were always eminently readable; so are his poems. This collection of 50 ranges from the title poem, about a fossil of a leaf he kept on his desk, to a eulogy to a friend's dead poodle. He also wrote a poem about the black snake that:

came through the boards of the old bridge
black, glistening, innocent as before the Fall
and my wife
as befits women, saw him first and screamed
All he wanted was to bask in the sun and I would
wager
the whole Biblical story came from a similar
imputation
of the wrong motives

Although many of Eiseley's poems stemmed from his career interests, (Egypt, fossils, birds, the ephemeral nature of man), many deal with current events, the same events to which we non-poets were also exposed. Do you remember when the Mars unmanned-prober refused to

respond to its commands? Did you consider writing a poem about it?

This slave stubbornly refused to act.
Two hundred million miles away it could receive
orders
but not be punished or dismantled. It had
discovered
free will. It would not take dictation, it sulked
though the beautiful
skies continued to be received. But with the arm
and the little laboratory
it tantalized and played with us.
Furtively now in the night
who knows what thoughts
impinge on its antennae, or what the dragon eye
suppresses in the near foreground.
Sulk, Viking, for the sake of the universe.

Among their other virtues, Eiseley's poems are comprehensible even to those not accustomed to including poetry among their regular reading fare. This collection is a good one with which to learn the virtues of enriching one's reading diet.

BERNADINE Z. PAULSHOCK, M.D.

THE EYE BOOK by John Eden, Viking Penguin, Inc., New York, 1978. 218 pp. Illus. Price \$3.95. Paperback.

Dr. John Eden has taken the time from a busy practice to answer the thousands of questions that patients seem to have about eyes and eye diseases. His comprehensive volume is designed to provide answers to the questions you always wanted to ask and to expose myths for what they are. He carefully defines refractive errors and discusses ocular physiology in the plainest of terms. He describes everything from glasses to the fact that masturbation doesn't blind you (it just causes baldness!).

The only area of weakness in the book is in the area of pediatric ophthalmology where he fails to separate amblyopia (lowered vision because of failure to use one eye) and strabismus (crossed eyes) and, therefore, confuses the prognosis and goals for therapy for each. Also, the author is uncertain as to what age a child can

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Book Reviews

be examined (any age) and at what age visual acuity is premanently impaired from amblyopia.

In the long run, Dr. Eden has done an excellent job in translating the complex field of ophthalmology and its Latin accoutrements into understandable terms. As long as people can converge the rays of light reflecting from these 218 pages, they will get some excellent explanations from this book. This is a book that certainly can be read by doctor and patient alike. It rates better than 20/20.

ROBERT ABEL, JR., M.D.
RALPH S. MILNER, M.D.

❖ ❖ ❖

DIABETES A Clinical Guide by Jeanne R. Bonar, M.D., Medical Examination Publishing Company, Inc., Garden City, New York, 1977. 354 pp. Price \$10.00. Spiral-bound.

Diabetes mellitus and its spectrum of complications are frequently encountered in any medi-

cal practice. Consequently, a concise text summarizing the pathophysiology and management of the diabetic patient would be invaluable. This book, which should fill that need, is unfortunately already dated. Although published in 1977, the majority of references are more than five years old, so that important recent trends in diet therapy, management of the pregnant diabetic, and treatment of insulin allergy are inadequately discussed in view of current knowledge. Laboratory advances with important clinical implications such as insulin receptor dynamics, proinsulin, and C peptide measurements are not mentioned.

Discussions of the complications of diabetes are adequate but uninspired. The index is excellent, and it deserves to be mated with a better text. In summary, this would have been a useful book four years ago, but it is not aging gracefully.

WILLIAM L. JAFFEE, M.D.
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In Brief

Speakers on "Ask the Doctor"

Speakers for January 1979 on the Tuesday radio program (11:05 a.m., WDEL), produced by the Medical Society of Delaware are: January 2, *Ralph S. Milner, M.D.*, Pediatric Ophthalmology; January 9, *John E. Hocutt, Jr., M.D.*, The Role of the Family Physician; January 16, *Charles L. Reese, III, M.D.*, Parkinson's Disease; January 23, *Forrest G. Hawkins, M.D.*, Year of the Child; January 30, *Stephen L. Hershey, M.D.*, Lower Back Pain.

In the News

Jack Gelb, M.D., Wilmington, has been appointed for a three-year term to the Commission on Health Care Services of the American Academy of Family Physicians.

Henry R. Cowell, M.D., Wilmington, has been given the first annual award of the Eastern Orthopedic Association. The Award, "in recognition of outstanding research related to the spine" is made possible by the Keim Spinal Research Foundation.

New officers for the Sussex County Medical Society are: *Palmarin C. Francisco, M.D.*, President; *Harvey E. Mast, M.D.*, Vice-President; *Jose Gontang, M.D.*, Secretary-Treasurer. Trustees to the Medical Society of Delaware will be *Dr. Francisco, Anis Saliba, M.D.*, and *C. E. Graybeal, M.D.*

The Kent County Medical Society elected the following new officers: *Joel R. Temple, M.D.*, President; *Honorata Bengzon, M.D.*, Vice-President; *William R. Mast, M.D.*, Secretary-Treasurer. Kent Trustees will be *Dr. Temple, Bruce L. Bolasny, M.D.*, and *John C. Sewell, M.D.*

Access Guides

A 16-page directory listing 275 access guides to cities and transportation facilities throughout the United States and around the world is available free to disabled and elderly persons as well as to organizations serving their needs. The directory describes an area's hotels, restaurants, theaters, churches, transportation facilities, and other features in terms of their physical accessibility to persons with limited mobility. Individuals may order their free copy by writing: Access Guide Directory, Rehabilitation International USA, 20 West 40th Street, New York, New York 10018. Organizations serving the disabled and elderly may order copies in quantity.

Heart Grants-in-Aid

Deadline for receipt of grant-in-aid applications for research in the area of heart and vascular diseases for the period beginning July 1, 1979, is January 31, the American Heart Association of Delaware has announced. Applications may be obtained through the Heart Association offices: Wilmington, 654-5269; Georgetown, 856-7386; Dover, 734-9321. Grants are awarded on a one-year basis and only to non-profit institutions. Investigators must possess an M.D., Ph.D., or D.V.M. degree.

CLINICAL NOTICES AND MEETINGS

Office Dermatology The American Academy of Dermatology and the University of Nevada School of Medical Sciences will sponsor **PRACTICAL OFFICE DERMATOLOGY FOR THE PRIMARY CARE PHYSICIAN**, February 16-18, Las Vegas Hilton Hotel, Las Vegas, Nevada. The course meets the criteria for 12 Category I credit hours of the AMA Physician's Recognition Award. For information contact: American Academy of Dermatology, P.O. Box 552, Evanston, Illinois 60204. Telephone (312) 869-3954.

Johns Hopkins Courses The Johns Hopkins University will present the following programs which are approved for Category I credit towards the Physician's Recognition Award of the AMA. For information contact: Office of Continuing Education, The Johns Hopkins University School of Medicine, Turner Room 22, 720 Rutland Avenue, Baltimore, Maryland 21205. Telephone (301) 955-5880.

UPDATE OF SURGERY—1979, January 31-February 2.

CARDIOPULMONARY NUCLEAR MEDICINE, February 15-17.

PROBLEMS IN ADULT PRIMARY CARE, March 3, Baltimore City Hospitals, Baltimore.

PRACTICAL CARDIOLOGY FOR THE PRACTICING ANESTHESIOLOGIST, March 26-30.

Internal Medicine The Alton Ochsner Medical Foundation will present **PRACTICAL INTERNAL MEDICINE FOR THE PRACTITIONER**, March 30-31, Ochsner Medical Institutions, Monroe Hall, New Orleans, Louisiana. The program meets the criteria for 12 credit hours in Category I of the Physician's Recognition Award of the AMA and 12 elective hours by

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the AAFP. For information contact: Continuing Education, Alton Ochsner Medical Foundation, 1516 Jefferson Highway, New Orleans, Louisiana 70121. Telephone: (504) 837-3000, X5888.

**University of
Maryland Courses**

The University of Maryland School of Medicine will present the following courses:

BURN WORKSHOP, February 1-2, Baltimore Hilton Inn.

GASTROENTEROLOGY FOR THE PRIMARY CARE PHYSICIAN, March 9-10, Cross Keys Inn, Columbia, Maryland.

SELECTED TOPICS IN FAMILY PRACTICE, every Thursday evening, March 1-April 5, place to be announced.

THE FOURTH ANNUAL SYMPOSIUM ON ADVANCES IN CANCER TREATMENT RESEARCH, April 19-20, Friendship International Airport, Baltimore, Maryland.

ADVANCES IN TRANSFUSION AND COAGULATION BIOLOGY, April 26-27, Annapolis Hilton Inn, Annapolis, Maryland.

For information on any of the listed courses, contact: Program of Continuing Education, University of Maryland School of Medicine, 10 S. Pine Street, Baltimore, Maryland 21201. Telephone: (301) 528-3956.

**For the General
Internist**

The Division of General Internal Medicine, Medical University of South Carolina, will present NINE NON-INTERNAL MEDICINE TOPICS FOR THE GENERAL INTERNIST, March 7-9, Mills Hyatt House Hotel, Charleston, South Carolina. The program is approved for 17½ hours of Category I credit. For information contact: Ms. Gail M. Hogan, Division of Continuing Education, Medical University of South Carolina, 171 Ashley Avenue, Charleston, South Carolina 29403. Telephone: (803) 792-4431.

**Diagnostic Radiology
and Nuclear
Medicine**

The Johns Hopkins Medical Institutions are sponsoring the 7th Annual Symposium on PRACTICAL ADVANCES IN DIAGNOSTIC RADIOLOGY AND NUCLEAR MEDICINE, April 17-20. The program is approved for 32 hours of Category I AMA credit. For information contact: Program Coordinator, Turner Auditorium Room 22, 720 Rutland Avenue, Baltimore, Maryland 21205. Telephone: (301) 955-5880.

ACP Courses

The following programs, approved by the American Medical Association for Category I credits toward the Physician's Recognition Award, are sponsored by the American College of Physicians. For information contact: ACP, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

THE FIRST 12 HOURS—EMERGENCY MANAGEMENT OF THE CRITICALLY ILL, May 3-5, University of Toronto and Mount Sinai Hospital, Toronto, Ontario, Canada.
DECISION-MAKING IN CLINICAL PRACTICE, May 10-12, Washington Hilton, Washington, D.C.

RHEUMATOLOGY FOR THE NON-RHEUMATOLOGIST, May 16-18, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania.

CARDIAC AUSCULTATION AND CARDIAC EXAMINATION, May 16-18, Mayo Clinic, Rochester, Minnesota.

DELAWARE REGIONAL MEETING, May 29, Academy of Medicine, Wilmington, Delaware. For information contact: Robert W. Frelick, M.D., Suite 28, Professional Building, Augustine Cut-Off, Wilmington, Delaware 19803.

Financial Seminar

A FINANCIAL PLAN SEMINAR sponsored by the Medical Society of Delaware will be held at the Wilmington Country Club on January 15 at 7:30 p.m. The speaker will be Nicholas C. McDaniel, Esquire, Vice President of Financial Planning Services, Dean Witter Reynolds, Inc.

Sports Seminar

A Seminar on MEDICAL ASPECTS OF SPORTS, co-sponsored by the University of Delaware and the Medical Society of Delaware, will be held on January 13 at the John M. Clayton Hall, North Campus, University of Delaware from 7:45 a.m. to 4:15 p.m.

In Brief

Family Lecture Series

A lecture series co-sponsored by the Junior League of Wilmington and the College of Human Resources of the University of Delaware entitled **THE FAMILY FOUNDATION: TODAY'S CHILD—TOMORROW'S ADULT** will be presented on Tuesday evenings (January 30-February 27) at 7:30 p.m. at the Goodstay Center, Pennsylvania Avenue, Wilmington. Ronald J. Pion, M.D., Chairman of the Board, Media Institute of Medicine, Honolulu, Hawaii, will deliver the final lecture "Adolescent Sexuality" on February 27.

CLASSIFIED AD SECTION

Advertisements under the Classified Ad Section are charged at the rate of 30 words or less, set solid. One insertion \$4.00. Call the Journal office, 658-7596 for further information or placement. All advertisements are payable in advance. The Editorial Board reserves the right to edit copy. Closing date for new copy is the first of the month for inclusion in the current issue.

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military service at Walston Army Hospital, Fort Dix, New Jersey. Available July 1979.

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